**UNITED STATES DISTRICT COURT FOR THE**
**NORTHERN DISTRICT OF ILLINOIS**
**EASTERN DIVISION**

| | |
|---|---|
| **UNITED STATES OF AMERICA,**<br><br>**Plaintiff,**<br><br>**v.**<br><br>**COOK COUNTY, ILLINOIS; THOMAS DART, COOK COUNTY SHERIFF (in his official capacity); TONI PRECKWINKLE, COOK COUNTY BOARD PRESIDENT (in her official capacity); COOK COUNTY BOARD OF COMMISSIONERS (in their official capacity),**<br><br>**Defendants,** | **No. 10 C 2946**<br><br>**Judge Virginia Kendall** |

# Monitor Jeffrey L. Metzner, M.D.'s Report No. 14
# May 2, 2017

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# MEMORANDUM

**TO:** Donald J. Pechous, Esq.
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**FROM:** Jeffrey L. Metzner, M.D.
**DATE:** May 2, 2017
**RE:** *U.S.A. v Cook County, et al*
No. 10C2946

I have completed my assessment of the mental health services offered at the Cook County Department of Corrections (CCDOC) through Cermak Health Services of Cook County (CHSCC). I site visited CCDOC from April 10-14, 2017.

Sources of information utilized in compiling this report included the following:

1. review of documents provided in response to my written request for pre-site information, which included the following documents:
    a. status update to the Agreed Order,
    b. numerous mental healthcare quality improvement studies,
    c. 21 healthcare records of mental health caseload inmates,
2. interviews with many inmates in group settings in Division 8 (RTU and the Cermak units) and Division 2 and Division 10,
3. observation of treatment activities in Division 8,
4. information obtained from key administrative and clinical staff that included, but was not

limited to, the following persons:

a. Jay Shannon, M.D. (CEO, Cook County Health and Hospitals System),
b. Linda Follenweider, R.N., N.P. (Chief Operating Officer Hospital Based Services),
c. Connie Mennella, M.D. (Chair, Department of Correctional Health Services),
d. Nneka Jones Tapia, Psy.D. (First Assistant Executive Director),
e. Kenya Key, Psy.D. (Chief of Psychology),
f. David Kelner, M.D. (Chief of Psychiatry),
g. Jane Gubser (CCDOC Chief of Programs),

As always, I found the staff from CHSCC and CCDOC to be courteous and helpful throughout my five-day site visit.

In this report the term "inmate" will be used in contrast to "detainee" in order to be consistent with the Agreed Order's terminology, although the vast majority of persons admitted to CCDOC are pre-trial detainees.

**Overview**

The Cook County Department of Corrections consists of 9 main divisions in a group of buildings covering over 100 acres. The inmate count during November 15, 2016 was 8,029

Reference should be made to Appendix I for a more detailed summary of population and capacity information.

**Findings**

As per the June 3, 2010 memorandum regarding the June 2, 2010 meeting that included attorneys from the Department of Justice, attorneys and representatives of the Defendants, and the monitors, my findings relevant to the Mental Health Care section of the Agreed Order are summarized in Appendix IV (5-13-10 Agreed Order Mental Health provisions). Appendix IV includes excerpts from prior site assessment reports if they provide relevant contextual information. Consistent with the June 2, 2010 meeting, I have forwarded my input to the medical monitors who have primary responsibility for sections that overlap with various mental health provisions as summarized in the June 3, 2010 memorandum.

Appendix II summarizes the seventeen mental health provisions of the Agreed Order that have been in substantial compliance for at least 18 months, which includes one new provision being in this category. My assessment during this site visit did not raise any concerns that any of these provisions were no longer in substantial compliance. Appendix III summarizes mental health provisions of the Agreed Order monitored by other monitors.

Significant accomplishments since the November 2016 site assessment include substantial compliance being achieved with the following provisions:

**d. Cermak shall ensure clinically appropriate and timely treatment for inmates, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals or with Qualified Mental Health Staff, with appropriate, on-site supervision by a Qualified Mental Health Professional.**

**g. Cermak shall ensure timely provision of therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming. Cermak will develop and implement policies and procedures defining the various levels of care and identifying the space, staffing, and programming that are appropriate to each identified level of care.**

Substantial compliance with provision g is based on the assumption the 14.0 FTE mental health specialists' recently allocated positions will be filled in a timely manner and as well as the allocated psychiatrists' positions. The functional vacancy rate for the psychiatrists appears to be the lowest since the implementation of the Agreed Order. When allocated part-time and consulting psychiatrists' positions are translated in terms of FTEs, and psychiatric physician's assistant FTE positions are included, Cermak has approved funding for about 20 FTE line staff psychiatric provider positions in contrast to the 15.0 FTE line psychiatric positions described in the staffing summary from 2014. It appears that 3.0 FTE psychiatrists will be hired by August 2017. Cermak has demonstrated a commitment to an ongoing staffing needs assessment to ensure that the psychiatric staffing allocations will remain adequate. In addition, there is a filled 1.0 FTE Divisional Chief of Correctional Psychiatry position and a recently funded 1.0 FTE Associate Director of Correctional Psychiatry position that is being actively recruited.

The leadership of Kenya Key (Chief Psychologist, Ph.D.), David Kelner, M.D. (Chief Psychiatrist) and Carlos Gomez, Psy.D., Linda Follenweider, R.N., N.P (Chief Operating Officer Hospital Based Services), and Connie Mennella, M.D. remains very impressive. The working relationships between CCDOC and Cermak staffs continues to improve and is very good. The leadership demonstrated by Director Nneka Jones, Psy.D. remains impressive.

**Information Requests**

Appendix V summarizes my revised document request for my next site assessment scheduled for the week of November 13, 2017.The site visit will be three or four days in duration. At the present time I am planning to be on site from November 14-16.

Please do not hesitate to contact me if I can answer any further questions.

Sincerely,

Jeffrey L. Metzner, M.D.

**Executive Summary—Fourteenth Monitoring Report (Mental Health Provisions)**

Significant accomplishments since the November 2016 site assessment include substantial compliance being achieved with the following provisions:

**d. Cermak shall ensure clinically appropriate and timely treatment for inmates, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals or with Qualified Mental Health Staff, with appropriate, on-site supervision by a Qualified Mental Health Professional.**

**g. Cermak shall ensure timely provision of therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming. Cermak will develop and implement policies and procedures defining the various levels of care and identifying the space, staffing, and programming that are appropriate to each identified level of care.**

Substantial compliance with provision g is based on the assumption the 14.0 FTE mental health specialists' recently allocated positions will be filled in a timely manner and as well as the allocated psychiatrists' positions. The functional vacancy rate for the psychiatrists appears to be the lowest since the implementation of the Agreed Order. When allocated part-time and consulting psychiatrists' positions are translated in terms of FTEs, and psychiatric physician's assistant FTE positions are included, Cermak has approved funding for about 20 FTE line staff psychiatric provider positions in contrast to the 15.0 FTE line psychiatric positions described in the staffing summary from 2014. It appears that 3.0 FTE psychiatrists will be hired by August 2017. Cermak has demonstrated a commitment to an ongoing staffing needs assessment to ensure that the psychiatric staffing allocations will remain adequate. In addition, there is a filled 1.0 FTE Divisional Chief of Correctional Psychiatry position and a recently funded 1.0 FTE Associate Director of Correctional Psychiatry position that is being actively recruited.

In addition, all provisions of the Agreed Order are now in substantial compliance except for provisions o and p due to timeframe issues related to the mental health services request form process, which should be remedied within the next month.

CCDOC has continued to implement a plan for increased out of cell time for all inmates in segregation units as part of the CCDOC plan to gradually increase the recreational time for segregation inmates to at least three hours per day. In addition, the custody staff is providing increased access to out of unit recreational areas throughout the compound as well as increased correctional rehabilitation programming to many mental health outpatient level of care caseload inmates.

The leadership of Kenya Key (Chief Psychologist, Ph.D.), David Kelner, M.D. (Chief Psychiatrist) and Carlos Gomez, Psy.D., Linda Follenweider, R.N., N.P (Chief Operating Officer Hospital

Based Services), and Connie Mennella, M.D. remains very impressive. The working relationships between CCDOC and Cermak staffs continues to improve and is very good. The leadership demonstrated by Director Nneka Jones, Psy.D. remains impressive.

An additional one provision has now been in compliance for at least 18 months, which means a total of 17 provisions have been in compliance for at least 18 months.

Four (4) provision previously in partial compliance are now in substantial compliance, which means there are now seven (7) provisions that have been in substantial compliance for less than 18 months.

Only one (1) provision remains in partial compliance, although this provision should be in substantial compliance within a very short period of time.

**Summary of Compliance Findings**

The following provisions were assessed to be in substantial compliance (with the initial date of substantial compliance noted in parenthesis):

**Bolded provisions** indicate that the provisions have been in substantial compliance for more than 18 months.

**59. Assessment and Treatment**

**a. Results of mental health intake screenings (see provision 45.c, "Intake Screening") will be reviewed by Qualified Mental Health Staff for appropriate disposition. (6/12)**

**b. Cermak shall develop and implement policies and procedures to assess inmates with mental illness; and to evaluate inmates' mental health needs. Said policies shall include definitions of emergent, urgent, and routine mental health needs, as well as timeframes for the provision of services for each category of mental health needs. (10/12)**

c. Cermak shall ensure that any inmate who screens positively for mental illness or suicidal ideation during the intake screening process, through a mental health assessment, or who is otherwise referred for mental health services, receives a clinically appropriate mental health evaluation in a timely manner, based on emergent, urgent, and routine mental health needs, from a Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional. Such mental health evaluation shall include a recorded diagnosis section on Axis I, II, and III, using the DSM-IV-TR, or subsequent Diagnostic and Statistical Manual of the American Psychiatric Association. If a Qualified Mental Health Professional, or a Qualified Mental

Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, finds a serious mental illness, they shall refer the inmate for appropriate treatment. Cermak shall request and review available information regarding any diagnosis made by the inmate's community or hospital treatment provider, and shall account for the inmate's psychiatric history as a part of the assessment. Cermak shall adequately document the mental health evaluation in the inmate's medical record. (11/16)

d. Cermak shall ensure clinically appropriate and timely treatment for inmates, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals or with Qualified Mental Health Staff, with appropriate, on-site supervision by a Qualified Mental Health Professional. (4/17)

e. Cermak shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses. (4/17)

f. Cermak shall provide 24-hour/7-day psychiatric coverage to meet inmates' serious mental health needs and ensure that psychiatrists see inmates in a timely manner. (11/16)

g. Cermak shall ensure timely provision of therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming. Cermak will develop and implement policies and procedures defining the various levels of care and identifying the space, staffing, and programming that are appropriate to each identified level of care. (4/17)

h. Inmates shall have access to appropriate infirmary psychiatric care when clinically appropriate. (11/16)

i. **Cermak shall provide the designated CCDOC official responsible for inmate disciplinary hearings with a mental health caseload roster listing the inmates currently receiving mental health care. (6/12)**

j. **When CCDOC alerts Cermak that an inmate is placed in lock down status for disciplinary reasons, a Qualified Mental Health Professional will review the disciplinary charges against inmate to determine the extent to which the charge was related to serious mental illness. The Qualified Mental Health Professional will make recommendations to CCDOC when an inmate's serious mental illness should be considered as a mitigating factor when punishment is imposed on an inmate with a serious mental illness and to**

**minimize any deleterious effect of disciplinary measures on an inmate's mental health status. (10/12)**

k. **In the case of mentally ill inmates in segregation, CCDOC shall consult with Cermak to determine whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on Cermak's assessment.**

l. **Cermak shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals or by Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, in order to assess the serious mental health needs of inmates in segregation. Inmates who are placed in segregation shall be evaluated within 24 hours of placement and thereafter regularly evaluated by a Qualified Mental Health Professional, or by a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Cermak shall provide CCDOC with its recommendation regarding whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on the assessment of the Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional. (11/15)**

m. **Cermak shall maintain an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. Cermak shall create such a log within six months of the date this Agreed Order is executed. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication and dosages for inmates on psychotropic medications. In addition, inmate's medical records shall contain current and accurate information regarding any medication changes ordered in at least the past year. (6/12)**

n. **Cermak shall ensure that a psychiatrist, physician or licensed clinical psychologist conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. An appropriately credentialed registered nurse may conduct the in-person evaluation of an inmate prior to a seclusion or restraint order that is limited to two hours in duration. Patients placed in medically-ordered seclusion or restraints shall be evaluated on an on-going basis for physical and mental deterioration. Seclusion or restraint orders should include sufficient criteria**

**for release. (4/16)**

60. Psychotherapeutic Medication Administration

a. Cermak shall ensure that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis for appropriateness or adjustment. Cermak shall ensure that changes to an inmate's psychotropic medications are clinically justified and documented in the inmate's medical record.

b. Cermak shall ensure timely implementation of physician orders for medication and laboratory tests. Cermak shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, including movement disorders, and provide treatment where appropriate. (4/17)

**61. Suicide Prevention Policy**

**a. CCDOC shall participate with Cermak in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.**

**b. Cermak shall participate with CCDOC in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.**

**c. The suicide prevention policy shall include, at a minimum, the following provisions:**

**(1) an operational description of the requirements for both pre-service and annual in-service training;**
**(2) intake screening/assessment;**
**(3) communication;**
**(4) housing;**
**(5) observation;**
**(6) intervention; and**
**(7) mortality and morbidity review. (11/13)**

62. **Suicide Precautions**

**a. CCDOC shall ensure that, where suicide prevention procedures established jointly with Cermak involve correctional personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), correctional**

**personnel perform and document their monitoring and checks.**

**b. Cermak shall ensure that, where suicide prevention procedures established jointly with CCDOC involve health care personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), health care personnel perform and document their monitoring and checks.**

**c. CCDOC shall ensure that when an inmate is identified as suicidal, the inmate shall be searched and monitored with constant direct supervision until the inmate is transferred to appropriate Cermak staff.**

**d. Cermak shall develop and implement policies and procedures for suicide precautions that will set forth the conditions of the watch, including but not limited to allowable clothing, property, and utensils, in accordance with generally accepted correctional standards of care. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances. (11/15)**

**63. Cermak shall ensure that Qualified Mental Health Staff assess and interact with (not just observe) inmates on Suicide Precautions, and document the assessment and interaction on a daily basis. (11/10)**

**64. Suicide Risk Assessments**

**a. Cermak shall ensure that any inmate showing signs and symptoms of suicide is assessed by a Qualified Mental Health Professional using an appropriate, formalized suicide risk assessment instrument within an appropriate time not to exceed 24 hours of the initiation of Suicide Precautions.**

**b. Cermak shall ensure that the risk assessment shall include the following:**

**(1) description of the antecedent events and precipitating factors;**
**(2) mental status examination;**
**(3) previous psychiatric and suicide risk history;**
**(4) level of lethality;**
**(5) current medication and diagnosis; and**
**(6) recommendations or treatment plan. Findings from the risk assessment shall be documented on both the assessment form and in the inmate's medical record. (11/13)**

**65. Cermak shall ensure that inmates will only be removed from Suicide Precautions after a suicide risk assessment has been performed and approved by a Qualified Mental Health Professional, in consultation with a psychiatrist. A Qualified Mental Health Professional shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up. (11/15)**

**66. Suicide Prevention Policies**

a. **CCDOC shall ensure that suicide prevention policies established jointly with Cermak include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards.**

b. **Cermak shall ensure that suicide prevention policies established jointly with CCDOC include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards. (6/12)**

67. **DFM shall ensure that cells designated by CCDOC or Cermak for housing suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, unshielded lighting or electrical sockets). Inmates known to be suicidal shall not be housed in cells with exposed bars. (6/12)**

68. **Suicide Prevention Training**

a. **Cermak shall ensure that the Facility's suicide prevention curriculum for health care staff members, jointly established with CCDOC, addresses the following topics:**

(1) **the suicide prevention policy as revised consistent with this Agreed Order;**
(2) **why facility environments may contribute to suicidal behavior;**
(3) **potential predisposing factors to suicide;**
(4) **high risk suicide periods;**
(5) **warning signs and symptoms of suicidal behavior;**
(6) **observation techniques;**
(7) **searches of inmates who are placed on Suicide Precautions;**
(8) **case studies of recent suicides and serious suicide attempts (Serious suicide attempts are typically considered to be those that either were potentially life-threatening or that required medical attention);**
(9) **mock demonstrations regarding the proper response to a suicide attempt; and**
(10) **the proper use of emergency equipment, including suicide cut-down tools. (12/10)**

70. **Cermak shall document inmate suicide attempts at the Facility, as defined by the Suicide Prevention Committee's policies and procedure in accordance with generally accepted correctional standards, in the inmate's correctional record in CCDOC's new Jail Management System, in order to ensure that both correctional and health care staff will be aware at future intakes of past suicide attempts, if an inmate with a history of suicide attempts is admitted to the Facility again in the future. Cermak will begin to document this information within six months after execution of this Agreement. (6/12)**

86. **Quality Management and Performance Measurement**

**a. Defendants shall each develop and implement written quality management policies and procedures, in accordance with generally accepted correctional standards, to regularly assess, identify, and take all reasonable measures to assure compliance with each of the provisions of this Agreed Order applicable to that Defendant.**

**b. Defendants shall each develop and implement policies to address and correct deficiencies that are uncovered during the course of quality management activities, including monitoring corrective actions over time to ensure sustained resolution, for each of the provisions of this Agreed Order applicable to that Defendant. (11/15)**

The complete list of provisions that were in partial compliance is as follows:

59. Assessment and Treatment

o. Cermak shall ensure an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among inmates. Crisis services shall not be limited to administrative segregation or observation status.

p. Cermak shall ensure that inmates have access to appropriate acute infirmary care, comparable to in-patient psychiatric care, within the Cermak facility.

**Appendix I**

# Sheriff's Daily Report
# 4/10/2017

| Under the Custody of the Sheriff | |
|---|---|
| **TOTAL MALE AND FEMALE** | **9,811** |
| Jail Population | 7,620 |
| Community Corrections | 2,191 |
| | |
| **Jail Population** | |
| **TOTAL MALE AND FEMALE** | **7,620** |
| Division 2, Division 3 Annex, Division 6, Cermak, Division 08 RTU, Division 9, Division 10, Division 11 - Male Population | 6,794 |
| Division 4, Cermak, Division 08 RTU - Female Population | 481 |
| Division 15 - Outside Counties | 103 |
| Division 15 - Hospital | 26 |
| **Court-Ordered Programming Within Jail Custody** | |
| Division 16 - VRIC (Court Ordered) - Male Population | 22 |
| Division 3 Annex, Division 2, Division 6, Division 08 RTU - PRC (Court Ordered Drug Treatment Program) - Male Population | 141 |
| Division 4 - Women's Residential (Court Ordered Drug Treatment Program) | 53 |
| | |
| **Community Corrections Population** | |
| **TOTAL MALE AND FEMALE** | **2,191** |
| Electronic Monitoring (Court Ordered) | |
| Men | 1,930 |
| Women | 245 |
| M.O.M.s Program (Court Ordered) | 0 |
| VRIC Post Release (Court Ordered) | 16 |

## Cook County Department of Corrections Executive Director's Log

Monday, April 10, 2017

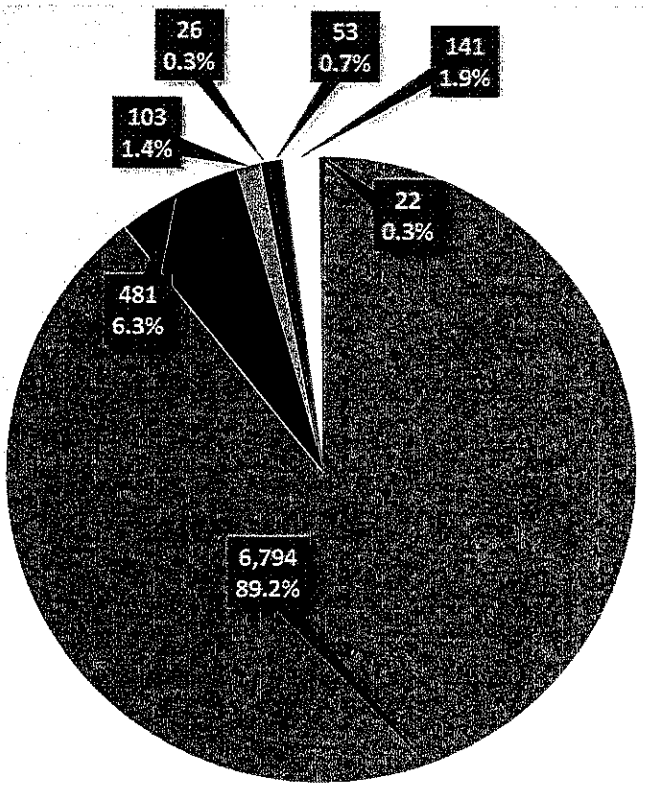
Prepared By: F. Khan

| | | |
|---|---|---|
| **Totals:** | **7,620** | **100%** |
| **Male** | 7,086 | 93% |
| **Female** | 534 | 7% |

| | Male | Female | Total | Capacity | No Place To Stay |
|---|---|---|---|---|---|
| Div 1 | 0 | - | 0 | 1,250 | 0 |
| Div 2 | 1,758 | - | 1,758 | 1,960 | 64 |
| Div 3 | 0 | - | 0 | 360 | 0 |
| 3 Annex | 481 | - | 481 | 768 | 18 |
| Cermak | 120 | 17 | 137 | 148 | 6 |
| Div 4 | - | 301 | 301 | 552 | 5 |
| Div 5 | 0 | - | 0 | 992 | 0 |
| Div 6 | 904 | - | 904 | 992 | 12 |
| Div 08 | 646 | 163 | 809 | 979 | 40 |
| Div 9 | 812 | - | 812 | 1,066 | 0 |
| Div 10 | 724 | - | 724 | 768 | 7 |
| Div 11 | 1,490 | - | 1,490 | 1,536 | 4 |
| Div 17 W. Residential | - | 53 | 53 | 152 | 0 |
| Div 15 - HP | 26 | - | 26 | - | 2 |
| VRIC In Camp | 22 | - | 22 | - | 0 |
| Outlying Counties | 103 | - | 103 | - | 0 |
| Totals: | 7,086 | 534 | 7,620 | 11,523 | 158 |

# Sheriff's Daily Report
# 4/10/2017

| Under the Custody of the Sheriff | |
|---|---|
| **TOTAL MALE AND FEMALE** | **9,811** |
| Jail Population | 7,620 |
| Community Corrections | 2,191 |




## Jail Population Behind the Walls

- Division 2, Division 3 Annex, Division 6, Cermak, Division 08 RTU, Division 9, Division 10, Division 11 - Male Population
- Division 4, Cermak, Division 08 RTU - Female Population
- Division 15 - Outside Counties
- Division 15 - Hospital

**Court-Ordered Programming within Jail Custody**

- Division 4 - Women's Residential (Court Ordered Drug Treatment Program)
- Division 3 Annex, Division 2, Division 6, Division 08 RTU - PRC (Court Ordered Drug Treatment Program) - Male Population
- Division 16 - VRIC (Court Ordered) - Male Population

Q. What does Behind the Walls mean?

A. The behind the walls jail population is physically housed under the Sheriff's custody 24 hours a day/7 days a week. This includes all the populations listed on the key above and pie chart to the left - Divisional populations male & female, Outside Counties, Hospital, PRC, Women's Residential, & VRIC. Detainees in court-ordered treatment programs (PRC, Women's Residential, VRIC) are housed at CCDOC 24 hours a day/7 days week.

**Appendix II**

**59. Assessment and Treatment**

**a. Results of mental health intake screenings (see provision 45.c, "Intake Screening") will be reviewed by Qualified Mental Health Staff for appropriate disposition.**

**Compliance Assessment:** Substantial compliance (since June 2012).

**b. Cermak shall develop and implement policies and procedures to assess inmates with mental illness; and to evaluate inmates' mental health needs. Said policies shall include definitions of emergent, urgent, and routine mental health needs, as well as timeframes for the provision of services for each category of mental health needs.**

**Assessment:** Substantial compliance (since October 2012)

**i. Cermak shall provide the designated CCDOC official responsible for inmate disciplinary hearings with a mental health caseload roster listing the inmates currently receiving mental health care.**

**Assessment:** Substantial compliance (since June 2012)

**j. When CCDOC alerts Cermak that an inmate is placed in lock down status for disciplinary reasons, a Qualified Mental Health Professional will review the disciplinary charges against inmate to determine the extent to which the charge was related to serious mental illness. The Qualified Mental Health Professional will make recommendations to CCDOC when an inmate's serious mental illness should be considered as a mitigating factor when punishment is imposed on an inmate with a serious mental illness and to minimize any deleterious effect of disciplinary measures on an inmate's mental health status.**

**Assessment:** Substantial compliance continues (since October 2012).

**k. In the case of mentally ill inmates in segregation, CCDOC shall consult with Cermak to determine whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on Cermak's assessment.**

**l. Cermak shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals or by Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, in order to assess the serious mental health needs of inmates in segregation. Inmates who are placed in segregation shall be evaluated within 24 hours of placement and thereafter regularly evaluated by a Qualified Mental Health Professional, or by a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional to**

**determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Cermak shall provide CCDOC with its recommendation regarding whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on the assessment of the Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional.**

**Compliance Assessment:** Substantial compliance (11/15)

**m. Cermak shall maintain an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. Cermak shall create such a log within six months of the date this Agreed Order is executed. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication and dosages for inmates on psychotropic medications. In addition, inmate's medical records shall contain current and accurate information regarding any medication changes ordered in at least the past year.**

**Compliance Assessment:** Substantial compliance (since June 2012)

***n. Cermak shall ensure that a psychiatrist, physician or licensed clinical psychologist conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. An appropriately credentialed registered nurse may conduct the in-person evaluation of an inmate prior to a seclusion or restraint order that is limited to two hours in duration. Patients placed in medically-ordered seclusion or restraints shall be evaluated on an on-going basis for physical and mental deterioration. Seclusion or restraint orders should include sufficient criteria for release.***

***Compliance Assessment:*** *Substantial compliance (since 4/16)*

**61. Suicide Prevention Policy**

**a. CCDOC shall participate with Cermak in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.**

**b. Cermak shall participate with CCDOC in a jointly established Suicide Prevention Committee charged with developing policies and procedures to ensure the appropriate management of suicidal inmates and with implementing and monitoring a suicide prevention program in accordance with generally accepted correctional standards of care.**

c. **The suicide prevention policy shall include, at a minimum, the following provisions:**
   (1) **an operational description of the requirements for both pre-service and annual in-service training;**
   (2) **intake screening/assessment;**
   (3) **communication;**
   (4) **housing;**
   (5) **observation;**
   (6) **intervention; and**
   (7) **mortality and morbidity review.**

**Compliance Assessment:** Substantial compliance (11/13)

**62. Suicide Precautions**

a. **CCDOC shall ensure that, where suicide prevention procedures established jointly with Cermak involve correctional personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), correctional personnel perform and document their monitoring and checks.**
b. **Cermak shall ensure that, where suicide prevention procedures established jointly with CCDOC involve health care personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), health care personnel perform and document their monitoring and checks.**
c. **CCDOC shall ensure that when an inmate is identified as suicidal, the inmate shall be searched and monitored with constant direct supervision until the inmate is transferred to appropriate Cermak staff.**
d. **Cermak shall develop and implement policies and procedures for suicide precautions that will set forth the conditions of the watch, including but not limited to allowable clothing, property, and utensils, in accordance with generally accepted correctional standards of care. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances.**

**Compliance Assessment:** Substantial compliance (11/15)

**63. Cermak shall ensure that Qualified Mental Health Staff assess and interact with (not just observe) inmates on Suicide Precautions, and document the assessment and interaction on a daily basis.**

**Compliance Assessment:** Substantial compliance (since November 2010)

**64. Suicide Risk Assessments**

a. **Cermak shall ensure that any inmate showing signs and symptoms of suicide is assessed by a Qualified Mental Health Professional using an appropriate, formalized suicide risk assessment instrument within an appropriate time not to exceed 24 hours of the initiation of Suicide Precautions.**

b. **Cermak shall ensure that the risk assessment shall include the following:**
   (1) **description of the antecedent events and precipitating factors;**
   (2) **mental status examination;**
   (3) **previous psychiatric and suicide risk history;**
   (4) **level of lethality;**
   (5) **current medication and diagnosis; and**
   (6) **recommendations or treatment plan. Findings from the risk assessment shall be documented on both the assessment form and in the inmate's medical record.** (11/13)

65. **Cermak shall ensure that inmates will only be removed from Suicide Precautions after a suicide risk assessment has been performed and approved by a Qualified Mental Health Professional, in consultation with a psychiatrist. A Qualified Mental Health Professional shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up.**

**Compliance Assessment:** Substantial compliance (11/15)

66. **Suicide Prevention Policies**

a. **CCDOC shall ensure that suicide prevention policies established jointly with Cermak include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards.**

b. **Cermak shall ensure that suicide prevention policies established jointly with CCDOC include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs, in accordance with generally accepted correctional standards.**

**Compliance Assessment:** Substantial compliance (since June 2012)

67. **DFM shall ensure that cells designated by CCDOC or Cermak for housing suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, unshielded lighting or electrical sockets). Inmates known to be suicidal shall not be housed in cells with exposed bars.**

**Compliance Assessment:** Substantial compliance (since June 2012)

68. **Suicide Prevention Training**

a. **Cermak shall ensure that the Facility's suicide prevention curriculum for health care staff members, jointly established with CCDOC, addresses the following topics:**
   (1) **the suicide prevention policy as revised consistent with this Agreed Order;**
   (2) **why facility environments may contribute to suicidal behavior;**
   (3) **potential predisposing factors to suicide;**
   (4) **high risk suicide periods;**
   (5) **warning signs and symptoms of suicidal behavior;**
   (6) **observation techniques;**
   (7) **searches of inmates who are placed on Suicide Precautions;**
   (8) **case studies of recent suicides and serious suicide attempts (Serious suicide attempts are typically considered to be those that either were potentially life-threatening or that required medical attention);**
   (9) **mock demonstrations regarding the proper response to a suicide attempt; and**
   (10) **the proper use of emergency equipment, including suicide cut-down tools.**

**Compliance Assessment:** Substantial compliance (since December 2010)

70. **Cermak shall document inmate suicide attempts at the Facility, as defined by the Suicide Prevention Committee's policies and procedure in accordance with generally accepted correctional standards, in the inmate's correctional record in CCDOC's new Jail Management System, in order to ensure that both correctional and health care staff will be aware at future intakes of past suicide attempts, if an inmate with a history of suicide attempts is admitted to the Facility again in the future. Cermak will begin to document this information within six months after execution of this Agreement.**

**Compliance Assessment:** Substantial compliance (since June 2012)

## H. QUALITY MANAGEMENT AND PERFORMANCE MEASUREMENT

86. **Quality Management and Performance Measurement**

a. **Defendants shall each develop and implement written quality management policies and procedures, in accordance with generally accepted correctional standards, to regularly assess, identify, and take all reasonable measures to assure compliance with each of the provisions of this Agreed Order applicable to that Defendant.**

b. **Defendants shall each develop and implement policies to address and correct deficiencies that are uncovered during the course of quality management activities, including monitoring corrective actions over time to ensure sustained**

**resolution, for each of the provisions of this Agreed Order applicable to that Defendant.**

**Compliance Assessment:** Substantial compliance (11/15)

**Appendix III**

## Appendix III

**Mental health provisions of the Agreed Order monitored by other monitors**

### H. QUALITY MANAGEMENT AND PERFORMANCE MEASUREMENT

**c. CCDOC shall participate with Cermak and DFM in a jointly established Health Care Quality Improvement Committee, to be charged with developing and implementing a joint quality improvement program. CCDOC shall contribute the time and effort of CCDOC staff members who, by virtue of their authority, current responsibilities, and/or past experience, can provide this committee with needed correctional representation.**

**d. Cermak shall participate with CCDOC and DFM in a jointly established Health Care Quality Improvement Committee, to be charged with developing and implementing a joint quality improvement program. Cermak will work with CCDOC and DFM to identify those CCDOC and DFM staff members who, by virtue of their authority, current responsibilities, and/or past experience, can provide this committee with needed correctional representation. Quality management programs related to medical and mental health care will utilize performance measurements to assess quality of care and timely access to care with quantitative and qualitative data analysis and trending over time.**

**e. DFM shall participate with CCDOC and Cermak in a jointly established Health Care Quality Improvement Committee, to be charged with developing and implementing a joint quality improvement program. DFM shall contribute the time and effort of DFM staff members who, by virtue of their authority, current responsibilities, and/or past experience, can provide this committee with needed correctional representation.**

**Compliance Assessment:** Refer to the report by Dr. Shansky (initially found to be in substantial compliance during 2011 and again during 2013)

**69. CCDOC shall ensure that security staff posts will be equipped, as appropriate, with readily available, safely secured, suicide cut-down tools.**

**Compliance Assessment:** Refer to the report by Susan McCampbell.

**Appendix IV**

P: AGREED ORDER

**D. MENTAL HEALTH CARE**

**59. Assessment and Treatment**

**c. Cermak shall ensure that any inmate who screens positively for mental illness or suicidal ideation during the intake screening process, through a mental health assessment, or who is otherwise referred for mental health services, receives a clinically appropriate mental health evaluation in a timely manner, based on emergent, urgent, and routine mental health needs, from a Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional. Such mental health evaluation shall include a recorded diagnosis section on Axis I, II, and III, using the DSM-IV-TR, or subsequent Diagnostic and Statistical Manual of the American Psychiatric Association. If a Qualified Mental Health Professional, or a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, finds a serious mental illness, they shall refer the inmate for appropriate treatment. Cermak shall request and review available information regarding any diagnosis made by the inmate's community or hospital treatment provider, and shall account for the inmate's psychiatric history as a part of the assessment. Cermak shall adequately document the mental health evaluation in the inmate's medical record.**

**Compliance Assessment:** Substantial Compliance (11/16)

**Factual Findings:**

**April 2017 Cermak Status Update**

April 2017
Total Jail Population as of 3/23/2017: 7,598

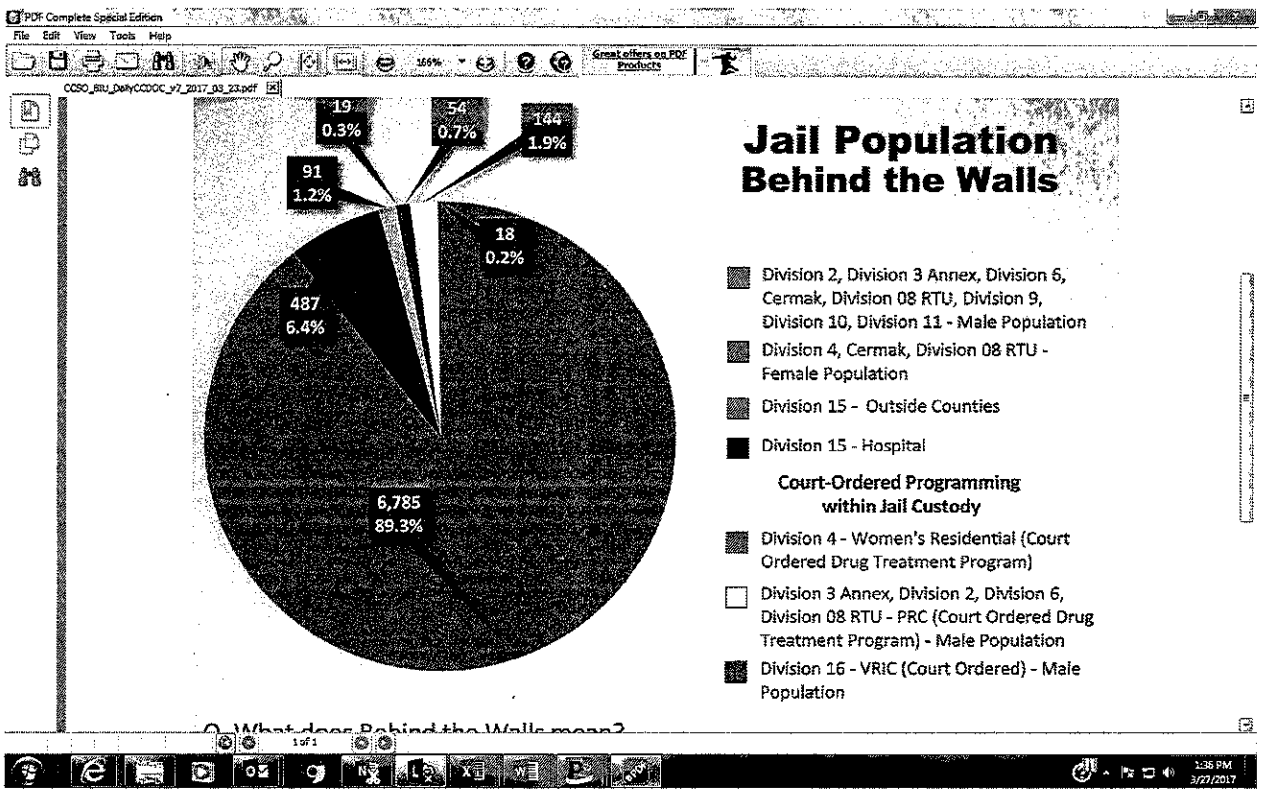
| | | | |
|---|---|---|---|
| P2-Outpatient Mental Health | 1679 | 22 % (of total) | 78% (of MH load) |
| P3-Intermediate Mental Health | 394 | 5.1% (of total) | 18.35% (of MH load) |
| P4-Psych. Special Care Units | 74 | 0.97% (of total) | 3.4% (of MH load) |
| Mental Case Caseload | **2,147 (29%)** | | |

October 2016
Total Jail Population as of 10/13/2016: 8,226

| | | | |
|---|---|---|---|
| P2-Outpatient Mental Health | 1711 | 20.7% (of total) | 76.62%9(of MH load) |
| P3-Intermediate Mental Health | 436 | 5.3% (of total) | 19.5% (of MH load) |
| P4-Psych. Special Care Units | 86 | 1.05% (of total) | 3.85% (of MH load) |

Mental Case Caseload **2,233 (27.14%)**

The number of patients on Mental Health Caseload has remained relatively stable. Furthermore, the proportion of detainees in Intermediate Level of Care and Outpatient Level of Care– P3 and P2, respectively, has remained constant. Various diversion programs have not diminished the proportion of the seriously mentally ill and the violent offenders.




All Providers, Psychologists, MSW and MHS continue to use their personalized access to the Jail Data Link database allowing them to source data about previous admissions to municipal and state institutions receiving federal grants or directly administered by the State of IL. All Providers, Psychologists, MSW and MHS have personalized access to the Jail Management System (CCOMS) allowing them to review charges, legal and disciplinary history in real time. All the WYSE terminals and desktops that Cermak utilizes across the compound (including RCDC) permit CCOMS access.

Mental health staff are routinely seeking releases of information for community providers during the intake process and post intake when needed. Dr. Gomez remains a lead coordinator for this task. Relevant data was obtained and is available as a separate CQI study in the PDF Appendix to this Status Update Report.

On average more than 47% of female detainees and approximately 24% of male detainees are

referred for secondary mental health assessment from the initial health screening. Additionally, appropriate identification of mental illness and placement on the mental health caseload at intake remains consistently over 90%. Please see Excel Appendix for Intake Referral data.

Dr. Gomez continues acting as the clinical supervisor in the RCDC area. Dr. Butler is in her second week of orientation to replace Dr. Gomez as RCDC Unit Director. During RCDC group supervisions case conferences, including peer review, are conducted to address the quality of secondary mental health assessments and identify outliers among staff. The main focus is to discuss quality of dispositions and risk assessments. Dr. Gomez conducted an ongoing audit and analysis of assessments and dispositions made by the Intake QMHP staff, find excerpts below. The full RCDC QI (MH Disposition at Intake) report can be found in the PDF Appendix.

The double blind audit of 42 intake mental health assessments reflected a high level of concurrence between the supervisor and individual assessors' dispositions. There was also a high level of interrater variability.

Psychiatry Face to Face visits:

| October | November | December | January | February |
|---|---|---|---|---|
| 2275 | 2095 | 1893 | 2291 | 2070 |

Physician Assistant Face to Face visits:

| October | November | December | January | February |
|---|---|---|---|---|
| 235 | 257 | 199 | 230 | 471 |

Physician Assistants continue to exceed productivity quotas and, overall, their performance is very good. Based on prior discussions, new PA who joined Cermak early in January was assigned primarily to P2 areas (Division IV).

Dr. Kelner reviewed psychiatry referrals originating in the intake process as per below (also see Excel Appendix for data):

Psychiatry Intake Referrals:

| Order Priority | Emergency | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Status | Seen | | Not Seen | | | | | | Total |
| Month | # | % | 2) Over 4hrs | | 4) No Note | | # | % | |
| | | | # | % | # | % | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2017_02 | 129 | 94.85% | 4 | 2.94% | 3 | 2.21% | 7 | 5.15% | 136 |
| 2017_01 | 119 | 97.54% | 2 | 1.64% | 1 | 0.82% | 3 | 2.46% | 122 |
| 2017_12 | 106 | 98.15% | 2 | 1.85% | | | 2 | 1.85% | 108 |
| 2017_11 | 156 | 96.30% | 3 | 1.85% | 3 | 1.85% | 6 | 3.70% | 162 |
| 2017_10 | 166 | 97.65% | 4 | 2.35% | | | 4 | 2.35% | 170 |

In February 2017 94.85% detainees were seen within 4 hours (in keeping with the timeframe) when referred with Psychiatry Emergent Referral. Out of the 5.15% that were not seen timely, 2.94% were still seen in RCDC (Intake) but outside of the 4 hour timeframe. 2.21% were not seen in Intake, as they were either fast tracked, given acuity, prior to Psychiatrists being able to see them, to PSCU and MSCU/detoxification units. Additionally, and in keeping with prior data, a small proportion of that cohort had orders for Psychiatry Intake placed in EMR when it was assumed by MHS that Psychiatry would be present on site, but then, due to call offs Psychiatrists did not show up and original orders were not cancelled. Of note is that, even when MH cancel those Psychiatry Emergent Referrals orders, Cerner still captures them subsequently. A work order has been created to address the fix in EMR.

| Urgent(P4) | 1) Within 24 hrs | | 2) Over 24 hrs | | No Note | | Total |
|---|---|---|---|---|---|---|---|
| **2_2017** | 79 | 96.% | 2 | 2.% | 1 | 1.% | 82 |
| **1_2017** | 68 | 93.% | 2 | 3.% | 3 | 4.% | 73 |
| **12_2016** | 58 | 95.% | 2 | 3.% | 1 | 2.% | 61 |
| **11_2016** | 75 | 89.% | 7 | 8.% | 2 | 2.% | 84 |
| **10_2016** | 87 | 96.% | 4 | 4.% | | | 91 |

In February 2017 96% of detainees referred for Urgent Psychiatry Referral were seen within 24 hours (in keeping with the timeframe). The 2% of detainees that were not seen within the next 24 hours were mostly detainees that fell into one of the following categories: a. Admitted on Fridays and weekends. Psychiatrists saw them later in the day and detainees who were assigned P4 level (were "slated" for PSCU admission) and then were diverted to MSCU and detoxification Units, thus delaying their contact with Psychiatry. Daily PSCU Mental Health Level of Care Tracker continues to allow Psychiatric Providers review lists of patients with P-alerts in MSCU and see when notes are due. b. Transferred to John Stroger Hospital due to medical problems and detox and could not be seen within 24 hours by Cermak Psychiatrists. An internal system of notifications between JSH Consultation and Liaison Psychiatrists and Cermak Providers serves to alert JSH C/L Service to CCDOC detainees' arrival.

| **Routine(P2/P3)** | 1) Within 14 days | | 2) Over 14 days | | 5) D/C over 15 days without Note | | 6) No Note | | Total |
|---|---|---|---|---|---|---|---|---|---|
| **2_2017** | 318 | 82.% | 30 | 8.% | 13 | 3.% | 25 | 6.% | 386 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1_2017** | 303 | 79.% | 34 | 9.% | 24 | 6.% | 24 | 6.% | 385 |
| **12_2016** | 257 | 74.% | 41 | 12.% | 26 | 7.% | 25 | 7.% | 349 |
| **11_2016** | 331 | 78.% | 38 | 9.% | 38 | 9.% | 18 | 4.% | 425 |
| **10_2016** | 385 | 88.% | 29 | 7.% | 17 | 4.% | 8 | 2.% | 439 |

In February 2017 318 (82%) detainees referred for Routine Psychiatry referral were seen within 14 days (in keeping with the timeframe). 30 (8%) were seen by Psychiatry outside of the timeframe (but under 22 days mark). Chart audit for the cases that did not have Providers' notes in EMR in February and January 2017 revealed that, when all the false positives and discharges from custody are subtracted, the actual number of detainees not seen as Routine Psychiatry Referrals was much smaller. Thus, out of 38 patients who were captured by Cerner as not having notes, only 10 did not truly have a note in February ( No Note and Scheduling Issues in the corresponding chart above) and out of 48 patients in January- only 9. The resultant calculation is 88% of patients in February and 80% patients in January had notes written within appropriate timeframes.

Two major recurring trends have been identified as a result of 87 chart audit/review:

- Cerner continues to capture many IDOC transfers (most of them were parole holds upon admission to CCDOC)/Electronic Monitoring releases/Furloughs/15SFFP/, and extraditions as being physically on campus and, therefore, they are seen as "never having contacts with Psychiatry".
- Scheduling and scheduling related errors remain an area of vulnerability. Cermak MH Leadership address scheduling issues with the Scheduling Supervisors. COO took over the scheduling Department and a new system of training and oversight is being introduced.

Daily reports for P Level detainees returning on the compound after hospital stays (15HP) are automatically generated, translated into an automated report, and become available to staff.

Outlying County returns reenter the compound after undergoing a Medical Mini screening as well as MH evaluation in RCDC. Their appointments with Psychiatry are rescheduled by a MHS. Medications are restarted once their housing is determined.

To further improve detainees' access to care and assure that Providers have enough time allotted to assess patients face to face and review medical records, a new Pilot scheduling program has been designed and being implemented in Division VI. The start date is April 1st. The new scheduling template will allow schedulers to schedule detainees for 40 minutes for their Initial Psychiatric evaluations and 20-30 minutes for subsequent follow up appointments, before the practice is expanded to the rest of Psychiatry Clinics on the compound.

In November 2016, the DOC formalized the process designed to facilitate after booking referrals from DOC to Cermak through the CCOMS/EMR interface by creating an alert for a "DOC Intake Mental Health Referral" for all detainees with certain charges compiled conjointly by Cermak/DOC. The alert is entered by DOC RCDC staff and is communicated to Cerner via electronic medical record. Due to expressed concerns regarding the interface and the possibility of the alert not transferring to Cerner, DOC continues to notify Cermak mental health staff of such referrals verbally and through use of the alert until the interface issues are resolved. Since November 95 DOC Intake MH Alerts have been assigned. 38 charts were audited (all March and February 2017); dispositions: GP- 19 (50%); P2-7 (18%); P3-5(13%); P4-7(18%). Since most of the alerts were assigned to males, dispositions for males elsewhere collected (Initial caseload February 2017-males, following MH Intake) were used as controls to compare the sensitivity of the existing alert:

Initial Case load Admitted on the Month of 02_2017 (include Discharge and non-active order status) Male
Mental Health Classification within 3 day after Admit
P2 - Outpatient Mental Health 300 62.89%
P3 - Intermediate Mental Health 86 18.03%
P4 - Infirmary Mental Health 58 12.16%

The false positives (detainees referred to MH and dispositioned to General Population by Mental Health staff eventually) constituted 50% of the audited population. On the other hand, the combined rate of admissions to P3 and P4 (SMI) made up 31% which approximates the 30% rate of referrals to those Levels of Mental Health Classification obtained by MH staff.

**April 2017 Metzner assessment:** Substantial compliance continues. The percentage of the total population on the mental health caseload as well as the percentages specific to the various levels of mental health care being used are consistent with national averages. The quality improvement studies relevant to the mental health screening process continues to be a very useful supervisory/peer review process as do the other audits relevant to this provision. Compliance with urgent and emergent psychiatric referral timelines continues to be maintained as does compliance with obtaining release of information consent forms when clinically appropriate.

**Recommendations:** Continue to monitor.

**d. Cermak shall ensure clinically appropriate and timely treatment for inmates, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals or with Qualified Mental Health Staff, with appropriate, on-site supervision by a Qualified Mental Health Professional.**

**Compliance Assessment:** Substantial compliance (4/17)

**April 2017 Cermak Status Update**

**COMPOUND HOUSING PLAN BY MENTAL HEALTH LEVELS OF CARE (as of April 2017)**

Cermak- P4 (Psychiatric Special Care Unit)- 2N acute male, 2W-acute and chronic female, 2S/2SE- male subacute, 2E- male chronic, P4 can also be housed on the third floor in Medical Special Care Unit under special circumstances. Housing on 3S for Mental Health reasons requires transfer orders from PCC/ Dr. Mennella. Patients with M4 and P4 can be housed on the Medical Special Care unit based on interdisciplinary decision.

- Division II: MALE MENTAL HEALTH HOUSING
    - Dorm 2: Mental Health Outpatient P2; **if any Mental Health Intermediates (P3) are placed there, MH staff works on transferring them to RTU; CCDOC houses detainees that attend MHTC (Mental Health Transition Center) in Division II Dorm 2
    - Dorm 1: NO MENTAL HEALTH HOUSING
    - Dorm 3: NO MENTAL HEALTH HOUSING
    - Dorm 4: NO MENTAL HEALTH HOUSING
- Division IV FEMALE MENTAL HEALTH HOUSING
    - (Women's Justice- SWJP): FEMALE MENTAL HEALTH HOUSING- 1st Floor
        - Mental Health Intermediates P3 (requires clearance from DWJS staff)
        - Mental Health Outpatients P2 (requires clearance from DWJS staff)
    - Mental Health Outpatient P2- 2nd floor
    - M2- Protective Custody
- Division V: NO MENTAL HEALTH HOUSING
- Division VI: MALE MENTAL HEALTH HOUSING
    - Westcare tier –2B (substance abuse, court ordered treatment program), Mental Health Outpatient P2
    - SMU- 2D
    - Protective Custody: 1A, 1B and 1C
        - Mental Health Outpatient P2 (only require mental health clearance prior to placement/ within 24 h if restricted housing rules apply) **No Mental Health Intermediates P3 should be cleared by mental health to transfer to PC in Division VI; they should only be cleared for PC in Division VIII RTU
- Division VIII RTU: MENTAL HEALTH HOUSING
    - 5th floor Females
        - Mental Health Intermediates P3 (tiers B, F) Mental Health Outpatients P2 and DETOX (all other tiers), Pre/postnatal
        - SMU (tier A) Protective Custody (tier E) (restrictive housing require mental health clearance prior to placement/within 24 h)
    - 4th floor Males
        - Mental Health Intermediates P3 (all tiers)
        - SMU (tier A) Protective Custody (tier E)

        - Mental Health Intermediates P3 (restrictive housing require mental health clearance prior to placement/within 24 h)
    - 3rd floor Males
        - Medical Intermediate M3s (may also be P2s) with overflow Mental Health Intermediate P3s
    - 2nd floor Males
        - Mental Health Intermediate Overflow P3
        - Intensive Management Unit (tier 2A)-P3
        - DETOX
- Division IX: MALE MENTAL HEALTH HOUSING
    - Protective Custody (Tiers 3G, 3H )
        - If conditions of confinement are more restrictive than GP, Mental Health Outpatient P2 require mental health clearance prior to placement/within 24h **No Mental Health Intermediates P3 should be cleared by mental health to transfer to PC in Division IX; they should only be cleared for SMU in Division VIII RTU
    - SMU- non-administrative SMU (Tier 1E, 1G, 1H; 1F- enhanced security tier)
        - Mental Health Outpatient P2 (require mental health clearance prior to placement/within 24h) **No Mental Health Intermediates P3 should be cleared by mental health to transfer to SMU in Division IX; they should only be cleared for SMU in Division VIII - RTU
    - General Population (all other tiers in the division)
        - Mental Health Outpatient P2
- Division X: MALE MENTAL HEALTH HOUSING: Mental Health Outpatient P2 **if any Mental Health Intermediates (P3) are placed there, MH staff works on transferring them to RTU
    - Protective Custody -1C (meeting criteria of SMU housing) and 2C
        - **No Mental Health Intermediates should be cleared by mental health to transfer to SMU/PC in Division X; they should only be cleared for SMU in Division VIII RTU
    - 2B- Therapeutic Tier ( non P3)
- Division XI: NO MENTAL HEALTH HOUSING
- Division XVI (Boot Camp): NO MENTAL HEALTH HOUSING; detainees on dose by dose medications cannot be in Boot Camp (and that excludes any patient on psychotropics)

**Compound Housing Discussions:**

**Residential Treatment Unit**

Average daily Population is 400 P3's and 190 P2's.
Average SMU/IMU population 23.
Of note, that there are no P3 patients housed outside of RTU and the need to create more P3 tiers to accommodate P3 overflow previously housed in Division X has significantly diminished.

**Updates: RTU Male Services**

RTU males are housed on the second, third and fourth floor of the RTU building. Psychiatric services in Male RTU have been expanded. Staffing levels in this high priority area (RTU) remain a focus for Psychiatry Administration. Additional psychiatric allocations were made following a series of discussions. Psychiatry Clinics were opened on the second floor of RTU. They were originally designed to differentially serve the needs of detainees housed on the 3rd and 2nd floor of RTU. At present, schedulers try to schedule detainees from the 2nd and 3rd floors to the second floor clinics. Present Psychiatric allocations in RTU are outlined in the staffing section of this Status Update report, see 59f.) Psychiatric allocations absorb Special Management Units with average daily census 18 (mixed Classification Units within the building housing detainees with various combinations of P3,P2, and M- Alerts) + Intensive Management Unit with average daily census 6 (housing detainees with P3 Level of Care). A designated Provider exists to provide psychiatric care for SMU/IMU populations and participate in the Multidisciplinary Treatment meetings on IMU. Dr. Sillitti is the Unit Director and coordinates all male services in RTU.

Since October of 2016, RTU Male Services has continued to focus upon increasing group programming hours for P3 detainees, expanding services to the protective custody tier, maintaining compliance with treatment plan timelines for intermediate care, addressing P3 overflow, and coordinating with CCDOC to minimize group cancellations. The following overview provides a summary of these efforts.

Prior to the staff rotation in December of 2016, RTU male services was short three staff, which significantly impacted programming hours for six intermediate care dorms, three special housing units (PC, SMU, IMU), and two overflow units. With the rotation and hiring of new staff, RTU male services currently has nine MHS III staff and three MHS II staff. One position remains vacant due to the illness and extended recovery of one MHS. Based upon current staffing and required programming for the ten aforementioned tiers, RTU inmates have an average participation of approximately 8 hours of programming for P3 dorms, 7 hours of programming for specialty units (SMU and Protective Custody), and 10 hours of group sessions for the IMU tier. As outlined in previous summaries, detainees attend the following core groups by bed number: Emotional Management, Interpersonal Skills, and Problem Solving. These sessions review relevant skills for all detainees in intermediate care. Voluntary groups are also offered to address the individual needs of patients. MH staff meet individually with detainees for orientation upon their admission to RTU to discuss the treatment program, review behavioral expectations, and identify treatment goals. At that time, detainees rank order their preferences for voluntary groups and are included in those sessions. Verification letters continue to serve as an incentive for participants who attend at least 75% of their groups. Consistent with previous estimates, approximately 17-30% of detainees on dorms earn letters for their participation.

Planned and unplanned staff absences remain the predominant reason for group cancellations. The most newly hired staff in RTU has been assigned to make up groups whenever possible,

which has been helpful. Scheduled programming hours will continue to increase for intermediate care with the addition of mental health specialists, particularly when the IMU program gains a separate and dedicated staff.

Programming on the Protective Custody tier (4E) has been well received by detainees. MH staff generally provide on tier sessions, but have conducted off tier groups when space is available and CCDOC approves movement. Initially, medium and maximum detainees were being seen more frequently due to the timing of the groups and "hours out" for those classifications. After realizing this disparity, MH staff have put forth increased effort to coordinate with tier officers and provide equal opportunity for minimum status detainees. Apart from staff absences, the most frequent barrier to programming on this tier has been staff attention to other clinical duties including mental health clinic, interagency evaluations, crisis intervention, and health service request forms. Again, programming on 4E will increase as mental health staff are added to the team.

The Special Management Unit (SMU) has posed the greatest challenge for group programming. Whereas Division 8 previously allotted two tiers (3A and 4A) for disciplinary housing, all males in RTU currently serve disciplinary time on 4A. Consequently, detainees who are general population and/or P2 level of care complete disciplinary time on the same unit with detainees in intermediate care. Over the past few months, several detainees who are well known for behavioral problems in Division 9 and 10 were housed in RTU for medical attention. They were placed on 4A due to their lengthy sanctions, which often exceeded one hundred days. Those detainees repeatedly engaged in maladaptive behavior on the tier including verbal and physical aggression, staff assault, flooding, smearing feces, and throwing liquids in the day room. Groups were repeatedly cancelled as a result of these unsafe behaviors, as tier officers needed to respond to the situations or lock down the unit. In addition, the general population and higher functioning detainees actively sought to interfere with group sessions in attempt to keep the day room open for "hours out" and television use. To illustrate, multiple P3 detainees admitted they refused group after they were either "bribed" or threatened. Other institutional factors contributing to group cancellations on this tier included a lack of handcuffs, conflicts with "hours out," and medication pass. These issues were discussed in interagency meetings, where potential solutions were considered. Alternative spaces for group sessions were explored, including the bullpen and patio when other rooms are in use. CCDOC recommended the installation of rings to the bullpen in order for the space to become a viable option for group sessions. MH staff continue to collaborate with nursing and tier officers to avoid scheduling conflicts.

In terms of treatment plans, each dorm has an assigned MHS III who conducts a core group for the tier and develops a 30 day treatment plan based upon the detainees' mental health diagnosis and self-report during the initial orientation session. The mental health team then aims to review the treatment plan within 90 days to discuss patient progress, clinical concerns, and recommendations for level of care. Weekly multidisciplinary (MDT) meetings are held on both day and evening shifts to facilitate team collaboration on treatment plans. Oftentimes, the number of people reviewed during the MDT does not allow time for direct contact with detainees

discussed. The clinical team on the evening shift therefore added group supervision sessions to meet with patients, discuss clinical goals, and offer feedback. According to MH staff, this time has been especially useful to reinforce concepts discussed in groups and to address clinical issues with detainees as a team.

All MHS III's were encouraged to create a database for their tiers in order to track the timeliness of 30 and 90 day treatment plans. Some MH staff have excelled at this task; others have struggled to maintain their excel sheets, which occasionally results in delay of MDT discussion and treatment plan review. Despite these challenges, compliance with both 30 day and 90 day P3 treatment plans has improved. The MH team will continue to streamline this process to effectively track and complete treatment plans within specified time frames.

Treatment plan review during weekly MDT meetings serves as the primary method by which the team monitors the P3 population in attempt to reduce overflow on other floors. Each week, MH staff place names on the MDT list for review due to an upcoming treatment plan revision or due to the patient's clinical presentation during treatment sessions. All detainees in SMU, PC, and overflow units are reviewed briefly to alert the team of clinical concerns. In addition, the team typically identifies an average of 9 to 10 individuals who are stable for outpatient care each week. MH staff observe many detainees to be highly motivated to remain in the dorm setting. Currently, CCDOC does not have dorm housing for P2/Maximum detainees. As a result, a portion of detainees often attempt to obtain preferential housing in RTU by exaggerating symptoms, requesting mental health treatment, and /or engaging in problematic behaviors. In January, Cermak administration proposed a therapeutic tier in Division 10 to provide additional support and monitoring for P2/Maximum and Medium detainees. The tier was approved to be started in mid-March. Ideally, the addition of this tier will help to increase mental health services for higher functioning detainees while decreasing the number of patients who intentionally return to intermediate care. While the motivation for readmission to a higher level of care than necessary remains present for some patients, the clinical staff do a great job of maintaining patients at the appropriate clinical level of care. Please refer to QI titled Readmission to P3 in the Appendix.

Since the last DOJ visit, the CCDOC and mental health teams have collaborated closely to address the most significant obstacles to group programming. A new joint schedule was developed to account for group programming as well as recreation. Following implementation of this schedule, cancellations due to recreation have decreased markedly on RTU 4$^{th}$ floor. Moreover, the lack of movement officers during the 3 to 11 shift previously resulted in repeated group cancellations. Over the past two months, CCDOC leadership approved for tier officers to assist with group observations, which has also reduced security related cancellations on the second shift. In terms of other endeavors, CCDOC and mental health staff have attempt to lead joint community meetings as often as possible (approximately once a month to once every two months) to address detainee concerns. Per MH staff, detainees have expressed appreciation for these meetings and the immediate actions that often follow.

**Updates: Intensive Management Unit**

The Intensive Management Unit (IMU) is located on the second floor or RTU. Dr. Kaniuk is the Unit's Director. The Psychiatrist assigned to SMU/IMU in RTU is Dr. Paschos. This specialized 10 bed capacity program is designed to provide increased structure and support for mentally ill detainees who have demonstrated significant problems in their functioning. The program consists of three successive phases (Assessment and Admission Phase-minimum 2 weeks; Stage 1- minimum 4 weeks; and Stage 2-minimum 4 weeks) which offer increased incentives as the detainee progresses. Recently the 3rd Phase (Residential) was introduced to accommodate program graduates who have lower functioning/significant deficits and expected to do poorly in the dormitories in RTU. All of the detainees selected for the program thus far incurred notable segregation time due to severe behavioral problems (e.g. assault against others; property damage; sexual misconduct; threats and noncompliance; coprophagia; insertion of foreign objects; ingestion of foreign objects; using ligatures for self-harm). These detainees were informed that their participation and successful completion of the program could result in absolution of segregation time for previous disciplinary tickets. Disciplinary Board approaches infractions incurred during detainees stay in IMU with deference to MH input. Additionally, a Letter of Completion is signed by the Superintendent and The Unit Director and is to be shared with Criminal Court Judges as a mitigating factor in the presentencing considerations.

The program continues to provide more than 10 weekly hours of structured out of cell therapeutic programming. Currently, two groups are held Monday through Thursday mornings. One group is performed on Friday morning. There is an evening group conducted Tuesday through Friday. One new staff member has been added to provide more hours of group programming. Group content includes, but is not limited to positive psychology, anger management, substance abuse, domestic violence, communication, coping skills, and DBT. The CRW comes to the tier on a daily basis. There is a weekly on-tier staffing where each detainee receives feedback regarding medication compliance, group attendance, and behavior in the program. A weekly staff meeting is held to discuss how each detainee is doing and to decide their status in the program. The medical social worker in the building addresses family issues, discharge medications, and provides linkage services to community agencies.

The IMU team meets for weekly MDT meetings and holds on tier meetings with the detainees every week to review treatment progress and expectations. The collaboration and communication amongst this disciplinary team has been essential to facilitate the progress of detainees. A joint training of new staff (manualized approach along the lines of trauma informed care) is planned since the original staff who began working in IMU in 2015 has been displaced. Currently, the team continues to work on maintaining consistency across shifts (especially 2nd and 3rd shifts) and personnel. Security personnel who are assigned to IMU must have knowledge of the program because participants have entitlements that are consistent with their level in the program, including how they are secured in the dayroom. Their level in the program also dictates which commissary products they can purchase. The use of incentives is further structured based on the advancement within the program.

Facilities Management, Cermak, and DOC leadership identified physical plant inefficiencies and repairing structural defects resulted in additional modifications and caulking of the gaps. Availability of safety garments has increased. Following discussions, safety garments were placed in the Shift Commanders' office. The plan for repairs of shower partitions damaged by detainees and their modification to prevent detainees from climbing on and then jumping off these elevated surfaces is in progress.

MH continues to address issues pertaining to safety garments' deployments. MH continues to recommend the deployment while the ultimate call whether to deploy the garments belongs to DOC supervisors. Cermak considers recommending deployment of safety garments when:

1. Detainees weaponize/ have a substantial risk of weaponizing their DOC's, bed linen, and parts of mattresses by wrapping them around their necks or otherwise inflict self-harm using the above objects to create ligatures
2. Detainees plug the toilet/are at substantial risk of plugging the toilet with their DOC's, bed linen, and parts of mattresses.
3. Detainees tamper with fire alarm safety equipment using the said objects.

Use of safety garments for valid clinical and security indications ought to be balanced against concerns that surround use of force on the compound.

Limited space and computers make it difficult to conduct all clinical activities and charting on days when all staff is present. Psychiatrist sees detainees through a sliding window opening in the Nurses' medication dispensation room/medical triage room on the tier and with immediate access to EMR.

Staff absenteeism has been a problem. There are employees assigned to do groups from the fourth floor of RTU during the 7-3PM shift but due to vacation and sick time, they are absent from time to time. In addition, groups may be cancelled due to medication pass, overflow detainees being transferred, power washing of cells, or behavioral issues.

The amount of Overflow P2/P3/detox patients sometimes placed in IMU overnight (mostly due to bed shortages in RTU) has been stemmed to a significant degree.

If there are any emergencies, mental health workers come to the tier during all shifts. If for some reason there is no mental health worker on during the 11PM-7AM shift, all emergencies are seen in Urgent Care. At times, the detainees attempt to create issues in order to get to the Urgent Care area, and be transferred to Stroger Hospital for better food and pain/benzodiazepine medication, if possible. These issues include self-injurious behavior, attempted hanging, foreign body insertion/ingestion, jumping off ledges, slipping in shower, eating magic shave foam, and banging head.

One challenge is providing sufficient dayroom time as the program census grows. The team has

mapped out showering times for those who display different levels of advancement within the program and different deficits/behavioral problems. The hours out had to be remapped, taking into accounts varying restrictions on detainees with different advancement within the program. It was further clarified that Assessment stage detainees can only come out with other A&A detainees. They are tethered to the table at all times. Stage 1 (cuffed) and Stage 2 (no cuffs) can come out together. However, CCDOC staff has the discretion to keep detainees separate following problematic incidents. Given the structure of the program, following these recommendations has not always been easy. MH and DOC Leadership continue to train staff to remain consistent with rules and expectations.

Cermak UC staff coordinates with RTU Medical and RTU DOC staff to have them primarily assessed in the RTU Dispensary following incidents, so that movement to Cermak care is minimized.

**Updates: Women's Services RTU 5th Floor and Division 4**

Cermak continues to provide Psychiatric Services to the mix of P3, P2, and SMU populations on the 5th floor of RTU. Psychiatrists presently provide services to mostly P3 detainees, as significant numbers of detainees with P2 Level of Care were transferred to Division IV. At the same time, most of the pregnant females from Division IV were transferred to the 5th floor of RTU. Dr. Briney is the Unit Director.

Division 4 houses P2 Levels female detainees in a celled setting. All the P3 detainees have been moved to RTU 5th floor. That included P3 pregnant detainees remanded to the rehabilitative program (SWJP) run by an outside Vendor (Salina and Associates). There are still almost 50 detainees enrolled in the program (court ordered). DOC moves them to Division IV from RTU 5th floor for therapeutic activities. There are only 5 of these detainees at this point. At the end of March Salina and Associates stopped providing services in the said program. CCSO's Office of Programmatic Services and the Office of Mental Health and Advocacy will be providing the services going forward. DOC coordinated with Cermak during the transition. The importance of sharing the same workload against the challenges of not sharing the same EMR was emphasized. Mutual roles and expectations were defined again. Agreements have been confirmed in terms of access to DHCRF process, routine and emergent services provided by Cermak staff. The mapping of the interagency cooperation has begun (including interdisciplinary staffing). Psychiatric Services have been provided by a Psychiatric Physician Assistant. Psychiatric presence has been expanded from 3 to 4 days a week.

*Division 4 -* Approximately 60 P2 patients were moved from RTU to div. 4, per CCDOC. There are about 175 P2 patients in div. 4, as well as general population, protective custody, and one women's justice tier. We have seen a slight increase in self-harm attempts since P2's were moved to div. 4. Div. 4 is fully staffed with two mental health specialists who complete PC rounds twice per week, mental health clinic, mental health evaluations (psych evals), HSR, and facilitate two groups per tier per month. Enrichment programs have been implemented for P2

and GP patients (Book Club, Theater Group, Anger Management, Yoga, Legal Aid, and sewing workshop). Superintendent Baker has been instrumental in improving multidisciplinary communications and increasing enrichment programs. There has been an increase in movement for CCDOC programming from RTU to div. 4 resulting in some missed Cermak clinic appointments. There will need to be efforts continually focused on increased communication to ensure that patient availability for appointments is consistent.

*RTU Housing* – Patients seem to generally prefer dorm housing. Housing units in RTU are being regularly power washed. No recent temperature complaints. Access to hygiene products and undergarments is reported to be consistent. On February 23rd CCDOC reassumed responsibility for distribution of hygiene products to all patients in RTU, including P3 level of care. Ongoing religious services are provided and CCDOC provides weekly Enrichment groups for P2 patients. A recent addition is the Mental Health Therapeutic Library created to allow patients access to books to utilize as a coping skill.

*P3 intermediate MH groups* – Averaging 7 hours of participation per patient per week on P3 tiers due to 50% staffing levels for three months. Additionally, all mental health specialists were rotated on 12/1/16 requiring a significant transition and training period, which impacted group hours. Intermediate mental health tiers are now fully staffed, oriented, and on track to achieve 10 hours per patient per week of patient participation. Current patient refusal rate is approximately 55%.

*Special Management Unit (SMU) and Protective Custody* – Mental health rounds are completed once per week on each tier. Patients are assessed by MH within 24 hours of placement in the SMU. RTU SMU and PC are assigned a mental health specialist. RTU SMU and PC patients received approximately 8 hours for mental health groups per week. Long term P3 patients receive a monthly individual therapy session and treatment planning. Div. 4 PC (GP and P2's) received mental health rounds twice per week.

As of April 10, 2017, there were 7 male detainees with P3 mental health alerts being housed on the male SMU tier in Division 08 RTU and there were no female detainees with P3 mental health alerts being housed on the female SMU tier. Table 1 shows that for the 7 male detainees on SMU tiers, the average length of stay is 5.9 days and the longest active SMU stay is 17 days.

Table 1: Current Length of Stay for P3 Detainees in SMU Tiers in Division 08 RTU

| | Detainees | Average LOS (days) | High LOS (days) |
|---|---|---|---|
| **P3 Male** | **7** | **5.9** | **17** |
| All Male | 14 | 17.7 | 163 |
| **P3 Female** | **0** | - | - |
| All Female | 4 | 16.5 | 25 |

| | | | |
|---|---|---|---|
| **Division 08 RTU Total** | **18** | **18.5** | **163** |

*Treatment Plans* – Patients meet with their tier mental health specialist to create a "treatment goal list." Each P3 patient is discussed in MDT staffing on a regular basis. Patients receive treatment cards (also to motivate patients) and to ensure they are aware of their treatment plan. Both the patients and the entire treatment team are involved in the treatment planning process, resulting in individualized treatment plans for each P3 patient. Nearly all (95%) of P3 treatment plans are initiated and updated on time and the quality of treatment plans has improved. There have been recent challenges, often due to patient movement, with having the five assigned tier mental health specialists completing the treatment plans. Compliance rate has decreased from 100% to 95% since the last site visit. Outpatient (P2) treatment plans are in compliance, as they are created by psychiatrist the treating psychiatrist during clinic appointments.

*Outpatient mental health (P2) Treatment Groups/ Community Groups*- P2's average 1.5 hours of group per month in div. 4 and RTU. Pregnant patients are now residing in RTU. Pregnant patients participate in SWJP prenatal programming, receive two community groups per month, and P3 pregnant patients receive monthly individual mental health contacts.

*Health Service Requests* - Completed according to policy - Patient's receive a face to face assessment generally within 48 hours of receipt of the HSR by a MHS III. Patients are abusing the HSR process. There has been a large increase of patients making demands for specific medications. They are submitting multiple, daily requests for the same issues. Usually, "anxiety" and "I can't sleep" and "Will request this every day until you give me what I want." Community groups, HSR contacts, and psych evaluations are frequently including sleep hygiene, anxiety management, and relaxation/ coping skills, but the patients are hyper-focused on receiving specific medications.

*Mental Health and Psychology Clinic* – A significant number of P3 and P2 patients receive individual therapy services in RTU and in Div. 4 for more personalized treatment. Wait times have greatly improved with the increase in mental health staff.

*Psych Evaluations* – The RTU provides 24 hour on-site psych evaluations and consultation. We are trying to improve consultation with CCDOC to refer appropriate psych evaluations according to policy (emergent issues, use of force, placement in special management unit, and suspected or confirmed physical or sexual abuse). Unit Director periodically attends roll call to discuss psych evaluations and referrals.

*Individual Therapy Sessions* – Each P3 patient is assigned to meet with her tier mental health specialist monthly for an individual mental health contact. One challenge in the consistency of these sessions has been security moving patients to different tiers.

*Linkage and Expressive Arts* - We continue to focus expressive arts and linkage services on P3 patients. P2's receive limited linkage services and discharge medications.

*Hygiene* – Hygiene has improved with P3 patients. Rise and shine program occurs five days per week. Patients displaying ongoing, serious hygiene concerns (generally psychotic) are discussed in MDT clinical staffing and are admitted to the psychiatric special care unit for increased support and a humanitarian shower (Non-aggressive patients).

*Self-Harm* – Womens' Services has a very low self-harm rate. Self-injuries that do occur are most often housed in segregation. We have seen some increase in self-injury in the SMU (P3 and very stable P2's), as they believe it will get them out of segregation and placed back on a tier. There has also been a small increase since P2's moved to div. 4.

**Additional Challenges:**

*Patient Motivation* - Mental health facilitates a movie discussion group for treatment compliant patients every two weeks. We are also providing a standardized letter of participation monthly for patients attending 75% of recommended treatment groups. Few women (15%) are receiving the letter of participation due to lack of consistent attendance. Long-term patients (particularly 5F) want new treatment videos and materials, reporting that they are bored. Despite ongoing and prior efforts and external motivators, the staff finds that only the women who are intrinsically motivated to participate in treatment are attending groups. The remaining patients enjoy sleeping and socializing on the tier.

*Concerns About Staff* - Some complaints have been received about specific mental health staff in terms of too frequently showing videos for group or not being as respectful as they should. Such issues have been addressed in individual and group supervision and resulted in a staff person being assigned different job duties.

Mental health has expressed concerns to CCDOC administration about the lack of available officers and officers leaving their post, creating a safety issue and barrier to providing mental health treatment. Additionally, CCDOC has been notified of specific security staff displaying rude and unprofessional behavior, in addition to being disruptive to mental health treatment services. Supt. Yoksoulian has been open to feedback from mental health regarding concerns.

*Abusing Medications* –Concern regarding patients trying to be prescribed as much medication as possible and having issues with patients hoarding and abusing the medications continues to be a challenge. The interagency treatment team works diligently to communicate about and address these issues.

**Compound Special Management Units:**

Compound SMU housing was assessed on 3/28/2017 with the following data captured:

- Compound Census as of 03/28/2017: 7,598
- RTU SMU and PC Census 03/28/2017: **39** (13 in disciplinary SMU , 26 of them are in Protective Custody );

- Out of **39** detainees- **9** (23%) are P2's and **30** (76%) are P3's ( 0.51% of the total compound detainee population are housed in RTU SMU)
- Total number of P3's in SMU (excluding Protective Custody): **6** ( 0.07% of the total compound detainee population )
- Division VI SMU Census ( all P2's): **59** ( 55 of them are in Protective Custody)
- Division IX SMU Census ( all P2's): **84** ( 46 of them are in Protective Custody)
- Division IV SMU Census ( all P2's): **7** ( all in protective custody)
- Total SMU population on the compound (including Protective Custody Population) **189** (2.4% of the detainee population)
- Total SMU population on the compound (excluding Protective Custody Population) **55** (0.72% of the detainee population)
- SMU settings: DOC and Cermak staff work together on overcoming inherently lower accessibility of patients to care; the overriding principle remains being able to provide essential psychiatric and mental health services regardless of housing; very helpful was the establishments and of the Compound wide Access to Care Workgroup with the participation of the Cermak operational leadership and most senior CCDOC executive leadership with the focus ( as the first priority on further improving access to care in Division IX which houses significant behaviorally problematic/institutionally disruptive P2 detainees in various SMU units)
- The Length of Stay in RTU SMU CQI study was conducted (APPENDIX)
- Cermak staff continues to work on modifying conditions of confinement for SMU populations. For RTU 5A ( Special Management Unit), the female SMU housing P3/P2 women, the four dates chosen at random were December 13th and 28th, 2016, and January 5th and 19th, 2017. The average length of stay for the 11 detainees in SMU on December 13th was 5.9 days, and there was only a single outlier (at 21 days) on that date. The subsequent three dates all revealed longer LOSs, averaging 13.2 days overall. There were two outliers on each of these three dates, ranging from 30 to 60 days. The CQI SMU Length of Stay Study can be found in the PDF Appendix.
- Cermak continues to strive to modify conditions of confinement for those who are housed on 4A (SMU male tier). For RTU 4A, on December 13th, the 12 male detainees housed there averaged 21.3 days, with six outliers ranging from 17 to 53 days. The average LOS for the subsequent three dates (analyzed in the CQI study referenced below) fell to 12.4 days. For the three later dates, there were a total of eight outliers overall, with lengths of stay ranging between 119 and 82 days. The CQI SMU Length of Stay Study can be found in the PDF Appendix.
- Modification of conditions of confinement for those individuals with Serious Mental Illness whose time in SMU exceeds 14 days would consist of providing more out of cell time to them. DOC Disciplinary Unit continues to issue tickets for P3 that do not exceed 14 days. Tickets do not always run concurrently. Cermak continues to provide structured therapeutic programming for SMI detainees in SMU 4A, further described in the updates. Detainees remain tethered to stationary furniture during out of cell group structured therapy/activities. Cermak will continue to target 10 hours of structured activities weekly/10 hours unstructured activities weekly provided to these detainees. Programming

activities on the male tier have been at times affected by institutionally disruptive detainees. Detainees with higher level of functioning, when introduced into the milieu with more regressed poorly functioning patients, have a tendency to adversely influence more regressed individuals. The importance of not introducing potentially predatory detainees into the RTU SMU environment is recognized.

- Cermak MH Department furnishes SMU detainees with the following services:
  - SMU rounds weekly ( in addition to weekly PCS rounds)
  - Psychiatry appointments ( regularly scheduled and walk ins)
  - Individual Behavioral Management Treatment Plans
  - Other essential services –individual supportive counseling , access to emergency and routine care as per DHCR process, crisis intervention, etc. (commensurate with their level of care)
- The Interagency process designed to streamline services in SMU Units in Division 9 was finalized in February 2017. Different Services in the following order- Disciplinary Board Hearings, Interagency Huddles, Nursing Triage, and MH /Psychiatry Clinics- were lined up and patient movement was coordinated with ERT Supervisors and Divisional Shift Commanders. New space was dedicated on 1S. A storage room was repurposed to allow seeing detainees for MH and Psychiatry appointments. A desk with EMR computer, patient chair, a wall ring (to tether detainees to) were all installed to enhance security during sessions. Significant effort is made to reduce SMU patients' movement within the building and, even more importantly, outside the building. What causes self-injury and acting out is multifactorial and, yet, it is believed that many detainees engage in acts of self-harm and other acting out in order to secure movement and break the monotony of SMU confinement. Telehealth continues to be utilized in order to utilize the incentive that movement to appointments represents to many detainees in SMU. Additionally, reducing the frequency and length of movement reduces the number of incidents of the use of force

**Correctional Programming in Special Management Units:** Effective January 2016, the DOC discontinued the use of administrative segregation. Additionally, in January 2016 the DOC identified detainees that had been causing the most disruption to the compound and moved them to one tier in Division 9 (Tier 1F). Many of these inmates were affiliated with the newly formed 'Savage Life' gang. The DOC staffed the unit with the Emergency Response Team (ERT). Expectations, unit rules and consequences of rule-breaking behavior were articulated in writing to each detainee. In March 2016, this special management concept was expanded to include Division 10 Tier 1A. In February and March 2016, the DOC reduced the number of detainees in special management, reducing the general population special management units (those in Divisions 6, 9 and 10) from 8 to 5 living units. In April 2016, the DOC piloted a revised procedure for restrictive housing in Division 9 to allow detainees in restrictive housing to have 1.5 hours out of cell each day. In May 2016, the DOC transferred all general population restrictive housing units to Division 9 and initiated Special Management Unit (SMU) housing. SMU tiers replaced disciplinary segregation and allowed detainees to receive at least 3 hours out of cell. All detainees are secured using a waist restraint system or security cuffs and are

monitored by an increased number of Officers who engage with the detainees on the tier. Detainees with recent violent infractions are often handcuffed to the dayroom tables as an enhanced security measure. Detainees in the SMU tiers may also be handcuffed to the wall while using the telephones. General population SMU tiers are staffed with at least 3 Officers and mental health SMU tiers are staffed with at least 2 Officers because the census is lower. All tiers allow for at least 2 detainees to interact in the dayroom at a time, though several of the tiers allow 8-12 detainees in the dayroom at a time depending on the makeup of the tier. The presence of correctional staff on the tier allows for increased positive engagement between correctional staff and detainees. It was important for the DOC to effect positive behavioral change among the detainees by encouraging the correctional staff to model such behavior. The tiers are managed by a combination of the DOC's ERT and Division 9 staff. Some of the most problematic detainees have successfully matriculated through the general population SMU and been allowed the opportunity to participate in divisional programs. One detainee that was heavily involved in the Savage Life gang and charged with several violent offenses had over 100 incidents of fights, batteries to staff and self-harm from July 2015 until the end of October 2016. Following encouragement from the ERT and Division 9 staff, the detainee's behavior began to shift and staff noted the detainee's desire to make behavioral improvements. The Division's Superintendent arranged for the detainee to have weekly meetings with two religious programming volunteers. At the advisement of the ERT staff, DOC leadership approved the detainee to be transferred from SMU to a programming tier where he could continue his involvement in the religious services program. In the following three months the detainee had no incidents of battery to staff, only one fight and a more than 80% decrease in self-harm incidents.

**Updates: Division 2 Dorm 2/minimum and medium security**

Population 390

Division Two – Dorm Two houses P-2 and M2 (outpatient level of care) patients within a dorm setting. There are ten dorms over three floors, with a census of approximately 44-48 detainees in each tier. It includes detainees with minimum and medium security classification. Services are maintained without significant changes. MHTC detainees are housed in the V house. Dr. Kaniuk is the Unit Director.

Telepsychiatry Clinic continues to provide reliable coverage for this Division and remains one of the strongest assignments in terms of productivity and meeting departmental expectations. Dr. Ward sees patients on a daily basis, with a combination of new evaluations and follow-ups. Dr. Marri is in Division Two – Dorm Two for two full days and usually sees detainees who need translation services.

Division Two – Dorm Two houses P-2 and M2 (outpatient level of care) patients within a dorm setting. There are ten dorms over three floors, with a census of approximately 44-48 detainees in each tier. It includes detainees with minimum and medium security classification. A dorm setting makes it easier for detainees to talk to the staff, since they are often within proximity of

the detainees. As a result of increased accessibility to mental health staff some of the requests are not related to mental health. Thus, the limited staff can become overwhelmed. Since there are only two interview rooms on the second floor (and one is being used by telepsychiatry Monday through Friday), it becomes more difficult to see detainees in a private setting. Quite often staff have to interview detainees outside the tier in any available space.

There is one employee assigned during the 7-3PM (Tuesday through Saturday) shift and one during the 3-11PM (Sunday through Thursday) shift. During the 11PM-7AM shift, all emergencies are seen in Urgent Care. Groups are conducted on a weekly basis in all ten tiers. They are composed of two parts: community issues and therapeutic intervention. The types of groups conducted are anger management, substance abuse, domestic violence, criminogenic thinking, and depression.

Security refers individuals who request an evaluation or have a question, as well as those who display behavior problems. This is done formally (Inter-Agency Health Inquiry) and informally. The mental health staff, along with the CRW's, meet with Supt. Martinez on a weekly basis.

There is a psychology clinic scheduled for Tuesday mornings. There are no problems seeing detainees in this clinic. Mental health clinic occurs on Wednesday and Thursday mornings. One mental health specialist is assigned to this clinic and it runs rather smoothly.

The nursing staff processes HSRF forms before giving them to mental health staff. On occasion, there is a delay in processing the forms. The detainees who write these requests are seen by the mental health staff (MHS III or psychologist) in a timely manner.

There is a medical social worker assigned to work in the building. He addresses family issues, discharge medications, and provides linkage services to community agencies.

**Updates: Division 6/Minimum and medium security**

Population 236

Division Six houses P2 and M2 (outpatient level of care) patients, along with GP (General Population) detainees, and transgender detainees. The Protective Custody tiers and the Westcare substance abuse program (2-B) house many of the P2 detainees, though others are scattered throughout the building. The changes in the Westcare program (January 2017) decreasing from three tiers to one resulted in an increase in requests for mental health evaluations. We suspect that detainees who were participating in programming during the week engaged in increased support seeking. The PC population includes detainees with special accommodations. There is one SMU tier in the building (2-D), which opened up on January 30, 2017.

There are now two mental health specialists assigned during the 3-11PM shift. This began on

March 7, 2017. Groups are scheduled for Tuesday and Wednesday (one daily) and security provides an escort. The groups contain two components: community milieu issues and therapy. The therapy group topics include substance abuse, anger management, criminogenic thinking, domestic violence, and depression.

Security refers individuals who request an evaluation or have a question, as well as those who display behavior problems. This is done formally (Inter-Agency Health Inquiry) and informally. The unit director (psychologist) and other disciplines meet with Supt. Beachem on a weekly basis. There are multi-disciplinary staffings scheduled twice a month.

As the population of P2 detainees grew, Psychiatry allocations were increased to accommodate the increased need. Presently a Telepsychiatric clinic is open on both shifts on Thursdays in addition to Psychiatry on site clinic opened on Fridays. If there are additional appointments needed, they are seen in Urgent Care on Thursday afternoons, from 2-4PM. Challenges can arise if both Protective Custody detainees and other individuals have to see psychiatry in Urgent Care. This means that security must bring one group at a time. On many occasions, the second group comes too late and misses the appointment. There is a psychology clinic scheduled on Monday mornings. Security brings the detainees on a timely basis. Mental health clinic occurs during the 3-11PM shift on Sunday, Monday, and Thursday. There have been no difficulties reported about this clinic. SMU rounds occur on Tuesdays and SMU groups are conducted there on Thursdays. The nursing staff processes HSRF forms before giving them to mental health staff. During the morning shift, the forms are faxed to Urgent Care and emergencies are seen as soon as possible. There is a medical social worker assigned to work in the building. He addresses family issues, discharge medications, and provides linkage services to community agencies. Dr. Kaniuk is the Unit Director.

**Updates: Division 9/Maximum and medium security**

Population 201

Division 9 houses P-2 and M-2 (outpatient level of care) patients, along with General Population detainees. Total population absorbs several Special Management Tiers in Division 9. That included 3H and 3G (Protective custody) and 1E, 1F,1G,1H (Special Management Tiers). 1F remains a tier which houses detainees that represent institutional threat/disruption as well as staff assault. This tier is afforded enhanced security parameters. Supervision of detainees is shared between ERT (Emergency Response Team) and Divisional DOC frontline staff. There are three Providers dedicated to the provision of Psychiatric services in Division 9. Psychiatric allocations are listed elsewhere. The number of detainees in 1E,1F,1G,1E fluctuates to some degree and the majority of patients, following the completion of their disciplinary tickets in SMU remain in Division 9. All three Psychiatrists follow detainees in SMU and outside of those Units. Unit Director is Dr. Augustine.

The Patient Safety and Enhanced Security Guidelines for patients who present with self-harm

(Foreign Body-ingestion/ insertion and pill ingestion) in Division IX were developed between Cermak and DOC Divisional/ DOC Cermak staff. They are designed to complement the enhanced security parameters and reduce the amount of disruption of operations. Specifically, the way detainees are staged outside of traditionally " desirable" areas in Cermak where these detainees congregate with others exchanging information and engaging in fights, was outlined and divisional Cermak /DOC staff collaborates using the following outline:

- Divisional staff to confer with the Urgent Care provider before transferring frequent "foreign body self-injury" and "pill ingestion" patients to the Urgent Care.
- The Urgent Care provider and nurse should discuss the details of the case, vitals and assessment of patient, and treatment plan options on a case by case basis. They should feel free to confer with the House Supervisor or PCC Leadership, if guidance is needed.
- Paying close attention to the security alerts assigned to a patient. Proceed with caution when assessing patients with "aggressive" alerts- "Spitter" (must be seen with a spit mask applied by DOC) , "313"- masturbators, "Urine/Feces projectors", "Aggressive toward staff" etc. Coordinate transfers to the Urgent care with CCDOC.
- Please notify MH of patients returning from an outside ER or hospital after a self-harm incident.

Analogous Guidelines for Management of Patients after Foreign Body Ingestion have been developed as a result of a collaborative effort between CCDOC, Department of External Operations, Cermak Administration, John Stroger Hospital Risk Management Department, JSH Emergency Room staff, and JSH GI/ Internal Medicine Department. These guidelines operationalize transfers, observation, alimentation, and treatment of patients engaging in frequent self-injurious behavior, for non-suicidal reasons.

It is proposed to utilize presently existing Telehealth rooms on 2N and 2S (Division 9) as MH offices. DOC and Cermak continue to work on improving access to "not regularly scheduled" care in Division 9. Presently, in addition to Cermak Movement List generated by Scheduling for all Cermak clinics and sent to DOC Divisional Leadership the day before, during morning huddles with Divisional DOC Leadership, lists of add on patients are generated and shared with DOC Supervisors/Shift Supervisors. Cermak Operational Leadership and CCDOC Executive Leadership worked out a pilot project designed to further improve the process and interagency interactions in Division 9. Designed to go live in the first days of April 2017, the following process will be utilized:

- The presently existing movement list will be discontinued
- An email will be generated by Cerner at 6 am to list all the patients scheduled for valid PCC, Dental, MH, and Psychiatry Clinics
- The said list will be emailed to the DOC email group including Shift Commanders
- As clinics begin and pts get moved to their appointments, AA's will proceed to check them in Cerner
- Cerner will continue generating periodic ( q30 minutes) updates to the list with the names

of those who ***yet*** to arrive to their scheduled appointments

- These updates will continue to be generated and shared with DOC group until the clinics are over
- A final wrap around list( summary) of the clinics' list will be generated at the end of a clinic and accompanied with the CSV's files also shared with DOC Supervisors
- Presently, the old process will continue to be utilized to have " unscheduled" detainees moved to clinics( generating list in morning huddles and otherwise and sharing them via email with Shift Commanders)

A separate CQI Access to Care Study for Division 9 was generated and is available in the PDF Appendix.

**Updates: Division 10/Maximum and medium security**

Population 465

Division 10 houses Maximum and Medium security P2 and M2 detainees. Unit Director is Dr. Augustine. Notably, due to the efforts exerted by the Cermak and CCSO Bed Control Departments, there are no P3 detainees in the Division. Additionally, there are two Protective Custody Units (1C and 2C) in the Division. There is one Full time Psychiatrist and two Locums Psychiatrists in Division X. Allocations are discussed elsewhere. Telepsychiatry clinic is open in Division X three days and continues to provide valuable supplementation to existing employed FTE's. In March 2017 the second Psychiatry workstation became Telepsychiatry compatible and now Division X can provide Psychiatry Services using two Telepsychiatrists at remote sites at the same time. Division X continues to utilize a dedicated Locums Telepsychiatry Clinic attendant. Access to care issues prompted a separate CQI No Shows study which can be found in the PDF Appendix.

**Updates: Combined Division 9/10**

Since the last summary the following services continue to be provided by Mental Health Specialists and one psychologist on Division 9, Super Maximum, and on Division 10, Maximum: evaluations for mental health conditions, psychological evaluations and assessments for suicidal risks and assessments of detainees to determine if there are concerns regarding placement in Special Management Units by CCDOC. This clinical team also provides therapeutic services which includes specialist clinics, group therapy, treatment plans, community meetings, weekly Special Management Unit Rounds, crisis intervention and processing of detainees mental health needs submitted via Health Service Requests and Inter-Agency Health Inquiries forms.

There has been an increase of Mental Health Specialist from two to three in Division 9, one on the am shift, (7 am -3 pm) and two on the 3-11 pm shift. They provide services to 24 Tiers. Currently, there are six Mental Health Specialists in Division 10, four on the am shift, 7 am -3 pm and two on the 3 pm -11 pm shift. They provide services to 16 Tiers. All urgent mental health needs that

occur on the 11pm – 7am shift are addressed by the Urgent Care staff.

**Accomplishments** are reflected in weekly provision of the above listed services and weekly provision of: Mental Health Specialist Clinics six days per week on Division 10 and seven days per week on Division 9, weekly Psychology Clinic on Mondays in Division 9 and on Fridays in Division 10, weekly Psychiatry Clinics on Division 9

Groups are conducted by Dr. Brian Waxler, Psychologist, on Division 9/1E on the first and third Tuesdays of the month.

After being suspended in August, 2016 (due to security concerns), Groups/Community Meetings resumed in Division 10 on October 19th. When groups resumed in Division 10, there were some challenges in having consistent supervision available. However, with the support of the Supt. Walsh and Director Reyes there has been gradual improvement. Since the last summary in October 2016 a total of 97 groups were conducted (Nov.-Feb.).

The challenge of lack of office space for Mental Health Specialists in Division 9 was resolved.

Mental Health leadership and staff submitted a proposal for a Therapeutic Tier in Division 10 on January 20th, 2017. The proposal to create the tier was an action plan to address the augmented need of a subset of the outpatient population and to provide a therapeutic equivalent to RTU for patients who have demonstrated a pattern of behaviors to remain in RTU when their level of care was stepped down. Documents describing the Therapeutic tier can be found in the Appendix. CCDOC approved the Therapeutic Tier during the week of March 13th and patient transfers began later that week. Cermak staff makes requests to CCDOC for transfers into the tier on a "rolling admission basis". CCDOC vets the requested patients for security related issues and moves those patients that are able to move to the tier. The program is voluntary, so patients do have the right to refuse. Cermak staff discuss the referral for the program with the patients to minimize refusal rates. Due to CCDOC bed space, we have not been able to make the tier a "closed" therapeutic milieu. Patients who are not referred to the program are housed on the tier and are sometimes disruptive to the programming.

One Mental Health Specialist has primary assignment for the Therapeutic Tier, 2B Division 10. This MHS coordinates with the psychologist and other providers to schedule, facilitate and enhance services to the Therapeutic Tier. Mental Health Staff began providing services on the Therapeutic Tier on March 19th, 2017. Further information about the programming on the tier can be found in the Appendix.

Mental Health Leadership and staff in Division 9 presented a proposal in January 2017 for a Behavior Management Unit Pilot Project to address identified detainees who are not diagnosed with severe mental illness but displayed chronic patterns of engaging in self-injurious behaviors, suicidal gestures and threats, as well as aggression towards others, sexually inappropriateness, and create other operational and institutional disruption. An assessment of small group of

identified detainees was completed. Several multidisciplinary meetings were held and a draft proposal, including drafted behavior management plans, was submitted on February 7th, 2017 for CCDOC's approval. Approval is pending.

The following challenges impact the delivery of mental health services on Divisions 9 and 10: The office space available for provision of Mental Health services on Division 10 continues to pose a potential risk due to the small space that results in physically close and uncomfortable proximity between staff and detainee.

On Division 9 the challenge of achieving 100% compliance in seeing detainees who are placed in Special Management Units (SMU) by CCDOC continues. The following factors continue to impact this compliance: sometimes there are no movement of detainees due to safety concerns, detainees refused to be seen, MHS staff are not always informed when a detainee is being placed in SMU or when the detainee is removed and returned after 30 days/24 hours out compliance, detainees are not referred when they are returned from outlying counties and hospitals.

Other challenges in Division 9 are being addressed by the access to care work group. Line staff have indicated that a shortage of CCDOC staff needed for escort and safety incidents have impacted the movement of detainees in need of mental health services. The Chief Psychologist conducted a QI study to review this concern that can be found in the Appendix. It is hoped that data collected regarding factors that impact access to care in Division 9 and the current pilot project will result in improvement in this area. Mental health staff are now scheduling all non-urgent health service request forms to assist in streamlining of scheduling mental health movement as part of this pilot.

**Recommendations:**

The increase in staff will help to enhance provision of mental health services in Divisions 9 and 10.

A proposal for a more appropriate office space needs to be identified to minimize the safety risks posed by the close proximity of staff to patient in Division 10.

Mental health and CCDOC will continue to dialogue and work to address compliance in regard to SMU admission evaluations.

**Mental Health Transition Center:** The Sheriff's Office Mental Health Transition Center (MHTC) has increased its participant caseload to about 150 participants. It remains a day treatment program at this time.

**April 2017 Metzner assessment:** Substantial achieved compliance has been made in offering at least 10 hours per week of structured therapeutic activities for inmates with a P3 classification, which is a significant accomplishment.

Since the November 2016 site assessment, RTU Male Services has continued to focus on expanding services to the protective custody tier, maintaining compliance with treatment plan timelines and coordinating with CCDOC to minimize group cancellations.

It is encouraging that the only overflow housing unit for P3 inmates is now located in the RTU and the length of stay in the overflow housing unit was reported to be not long. It is also encouraging that a "therapeutic" housing unit has been opened in Division 10 to serve as a transition for inmates being discharged from the RTU. This housing unit was opened during March 2017.

The RTU inmates' access to the patio has significantly increased for both male and female inmates. Funding has reportedly been obtained to winterize several of these patios by the end of 2017. In addition, an outside exercise yard is being constructed adjacent to the RTU with an optimistic date of completion being this summer.

During the morning of April 11, 2017 I observed community meetings in RTU units 5B (a medium-maximum security female dormitory) and 4H (a minimum-medium security male dormitory), which were competently managed by the mental health specialists. I also interviewed inmates in a community-like setting in units 4C (a minimum-medium security male dorm), 4F (a medium-maximum security male dormitory) and 5F (a maximum security female dormitory). Inmates were almost uniformly in agreement that the offered mental health groups were very beneficial to them with many of these groups reportedly being offered in a group room off the unit. Their report regarding access to outdoor patios and the gymnasium were consistent with the information provided in the status update section. Medication continuity issues were not present. Unlike many others site assessments, when asked about their prior experiences in either Cermak 2N or 2W housing units, inmates described much more positive treatment experiences. Most inmates reported meeting with the psychiatrist on at least a monthly basis. Timely access to the psychiatrist via the health care request process was variable. Many inmates were aware of the discharge planning services available to them.

Unlike other site visits, issues voiced by inmates related to conditions of confinement, such as access to cleaning supplies and the quality of the food, were minimal.

During the afternoon of April 11, 2017 I observed a treatment team staffing for the male RTU program. The staffing was attended by the relevant clinicians with very good multidisciplinary input provided. Inmates receiving their 30 day treatment plan were interviewed as part of the staffing process.

The male Special Management Unit (SMU) is located on the second floor of the RTU. This specialized 10 bed capacity program, designed to provide increased structure and support for mentally ill detainees who have demonstrated significant problems in their functioning, continues to evolve in a very positive manner. I observed the mental health rounding process in the SMU during the afternoon of April 11, 2017, which was done in a very competent fashion by

the mental health specialist. During the rounding process four inmates, all handcuffed, had unstructured out of cell time in the dayroom.

During the morning of April 11, 2017 I observed an out of cell group therapy being offered to female SMU inmates. Five inmates were handcuffed at two spider tables and one inmate participated through the food slot in her cell. Despite the large number of persons watching this process, the mental health specialist was able to successfully engage the inmates in a useful therapeutic activity.

I continue to have concerns relevant to psychiatric staffing in the RTU, which will be addressed in a later section (see 59.f).

P2 level of care inmates in Division II reported having increased access to an outdoor yard and/or downstairs recreational area. Many of these inmates were enrolled in the CCDOC's Mental Health Transition Center program that provided daily programming, which was very well received by the involved inmates. In general, these inmates had much less complaints regarding their conditions of confinement related, in large part, to the above programming. These P2 inmates reported that they generally saw a psychiatrist on about a monthly basis via the tele-psychiatry process. Continuity of medication issues were reported to be uncommon events.

During the morning of April 12, 2017, I observed the mental health rounding process within the SMU located within Division 9, which was done in a very competent manner by the mental health specialist. About 10 inmates were in the dayroom, all handcuffed, as part of their daily out of cell unstructured time. Four correctional officers were also present in the dayroom. The atmosphere within the SMU was reasonably relaxed.

I also met with inmates in a community meeting-like setting within Division 10 in four housing units (2B, 4B, 1C and 4A). Unit 2B, which is the "therapeutic" P2 housing unit, clearly had established a more therapeutic milieu as compared to most other Division 10 housing units. Inmates in the other housing units visited described mental health treatment to primarily consist of medication management with minimal access to monthly community meetings and/or small group therapies. Continuity of medication issues was not a problem in these units. Inmates reported access to the gymnasium on a 2-3 times per week basis. As compared to prior site visits, the tension level within these units were markedly reduced.

A Compound-wide Access to Care Workgroup has been established with the participation of the Cermak operational leadership and most senior CCDOC executive leadership. This workgroup is focusing as the first priority on further improving access to care in Division 9, which houses significant behaviorally problematic/institutionally disruptive P2 detainees in various SMU units. Improvements have already been made in reducing the number of "no shows" for scheduled appointments. The results of this focus will eventually have significance to other divisions within CCDOC.

CCDOC remains a leader nationally in reducing the use of housing units that are basically locked down (i.e., segregation housing) by significantly changing the conditions of confinement in such settings, decreasing the numbers of inmates classified to such settings and providing programs that should help many inmates work their way to lesser restrictive housing units. During April 10, 2017, there were a total of 154 inmates housed in a SMU, which represented about 2% of the total CCDOC population.

Significant improvement in the context of the RTU therapeutic milieu and conditions of confinement (e.g., significantly improved inmate access to off unit recreational time) throughout the compound were obvious during this site assessment. Opening of the planned outdoor RTU recreational yard will be a major accomplishment and will have a very positive impact on the milieu.

**Recommendations:** Continue to closely monitor the out of cell structured therapeutic time being offered to and used by RTU inmates as well as their access to outdoor patio and/or outdoor yards. Consider changing the threshold for therapy achievement letters to averaging 10 hours of participation per week in structured therapeutic activities.

See provision 59.f.

e. **Cermak shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses.**

**Compliance Assessment:** Substantial compliance (4/17)

**Factual Findings:**

**April 2017 Cermak Status Update**

Please see Appendix for Treatment Plan QI Audits for each level of care.

Separate CQI study of P2 Level of Care detainees receiving no medications can be found in the PDF Appendix.

Intensive Management Unit (IMU) staff generates Multidisciplinary Treatment Plans called Self-Management Housing Plans for each individual patient housed in IMU with weekly updates.

Interagency Behavioral Management Plans continue to be developed as needed by Unit Directors in concert the Chief Psychologist, the Chief Psychiatrist, and the full multidisciplinary team for more complex or difficult cases throughout the compound.

- P4 (Psychiatric Special Care Units): Psychiatric Special Care Units patients have

completed treatment plans within 72 hours of admission to the Psychiatric Special Care Unit (PSCU) by QMHP and the Treatment Team with a review and update triggered by changes in acuity (such as placement in therapeutic restraints or administration of emergency medications) and failure to achieve goals, but no less frequently than weekly.

- Once patients within PSCU's are determined to require subacute level of care, with regard to the frequency of Treatment Plan reviews, they will have their Plans reviewed by QMHP and the Treatment Team every 30 days for two months. After that, patients within PSCU's requiring chronic level of care will have their treatment plans reviewed no less frequently then every 90 days by QMHP and the Treatment Team from that point forward.
- P3(Intermediate Care): Mental Health Intermediate/residential level of care patients have completed treatment plans by a QMHP within 30 days of admission to that Level of Care, with review and update at least every 90 days thereafter.
- P2(Outpatient Care): Mental Health Outpatient level of care patients have completed treatment plans by a QMHP ( Psychiatrists) within 45 days of admission to that Level of Care, with review and update at least annually thereafter. New individualized free standing Master Treatment Plan Templates have been identified in Cerner. Although they were originally tailored to JTDC (Juvenile Temporary Detention Center) populations, Cermak started using them at CCDOC, while IT is modifying them to meet the needs of CCDOC campus. The new Master Treatment Plans will allow to create more individualized and focused plans as they incorporate: reflection of collaboration with the inmate, frequency of follow up for evaluation and adjustment of treatment modalities, referrals for lab work for medication monitoring, instructions about adaptation to the correctional environment, documentation of treatment goals and objectives, notations of clinical progress. It is of note, that Cermak started the interim process of the Rx Plan modification while preparing to unroll already purchased Behavioral Health Cerner Module. Estimated time of inception is summer 2017. The Behavioral Health Cerner module promises to greatly increase the efficiency and capabilities of EMR as it relates to providing care/treatment planning on CCDOC campus. Chief of Psychiatry introduced the new Master Treatment Plan Template in January 2017. Psychiatrists working in P2 setting received training and directed to start using the new Template. It is still allowable to supplement that Template with the Rx plan pertaining entries within the powernotes where Providers chart. The ultimate goal remains is to create individualized Master Treatment Plans for every patient in P2 Level of care within the requisite time frame while addressing detainees' serious mental health needs and have them updated three times a year/when goals are failed ( current Policy requires annual updates). The most recent number of Master Treatment across the compound as of 3/30/2017 is 610(36%), while the number of detainees on MH caseload in P2 Level of care is 1671. As a point of reference, as of 2/ 28/2017 the number of Master Treatment Plans was 480 (30%) with P2 count -1579. In absolute numbers, 130 Master Treatment Plans were created in the month of March. Given the fact that the project was launched in January 2017, this is a

significant progress and Psychiatry is steadily increasing the number of Master Treatment Plans.

Cermak collected data on the number of P2 Level of Care Detainees who receive no medications. It is recognized that the time expenditure and complexity of treatment management is decreased for these detainees.

**ALL ACTIVE P2 ALERTS FOR UNIQUE PATIENTS ON 3.30.2017**

| 3/30/2017 | HAS AT LEAST 1 PSYCH MED? | HAS DIPHENHYDRAMINE BUT NO OTHER PSYCH MEDS? | HAS NO PSYCH MEDS AND NO DIPHENHYDRAMINE ORDERS | TOTAL | % |
|---|---|---|---|---|---|
| 02D2 | 327 | 12 | 50 | 389 | 21% |
| 04 | 147 | 1 | 23 | 171 | 9% |
| 06 | 175 | 4 | 64 | 243 | 13% |
| RTU 2 | 12 | 0 | 1 | 13 | 1% |
| RTU 3 | 65 | 1 | 11 | 77 | 4% |
| RTU 4 | 4 | 0 | 2 | 6 | 0% |
| RTU 5 | 34 | 1 | 9 | 44 | 2% |
| 08-CM2N | 2 | 0 | 1 | 3 | 0% |
| 08-CM2W | 0 | 0 | 1 | 1 | 0% |
| 08-CM3E | 2 | 0 | 0 | 2 | 0% |
| 08-CM3N | 7 | 0 | 1 | 8 | 0% |
| 08-CM3S | 1 | 0 | 1 | 2 | 0% |
| 08-CM3W | 6 | 0 | 1 | 7 | 0% |
| 09 | 147 | 8 | 43 | 198 | 11% |
| 10 | 367 | 36 | 43 | 446 | 24% |

Aggregate data shows that 246 (14%) P2 Level of Care patients receive no psychotropics. Total Number of P2 patients as of 3/30/2017 is 1,671. Divisional breakdown is below:

2D2 15%
Div. IV 15.4%
Div. VI 36%
Div. IX 29%
Div. X 11%

**April 2017 Metzner assessment:** A QI study indicated that 92% of the 50 treatment plans

reviewed (a combination of RTP and acute care level of mental health care) were completed in a timely fashion. Problems were found in timely completion of updated acute care P4 treatment plan reviews. The quality of treatment plans continued to improve as a result of the implementation of the new treatment plan template for P2 inmates.

**Recommendations:** Continue to QI the above, with particular attention to treatment plan updates of acute care inmates.

**f. Cermak shall provide 24-hour/7-day psychiatric coverage to meet inmates' serious mental health needs and ensure that psychiatrists see inmates in a timely manner.**

**Compliance Assessment:** Substantial compliance (11/16)

**Factual Findings:**

**April 2017 Cermak Status Update**

**Vacancies.**

| POSITION TITLE | ACCOUNT # | VACANT | FILLED | SUM | % VACANT |
|---|---|---|---|---|---|
| **Divisional Chief of Psychiatry** | 110 | 0 | 1 | **1** | **0.0%** |
| **Associate Director of Correctional Psychiatry** | 110 | 1 | 0 | **1** | **100%** |
| **FT Psychiatrist** | 110 | 4 | 11 | **15** | **26.6%** |
| **PT Psychiatrist** | 133 | 2 | 3 | **5** | **40%** |
| **PT Consultant** | 155 | 2 | 1 | **3** | **66.7%** |
| **Chief Psychologist** | 110 | 0 | 1 | **1** | **0.0%** |
| **Psychologist** | 110 | 3 | 7 | **10** | **30%** |
| **Physician Assistant** | 110 | 0 | 2 | **2** | **0%** |
| **Social Worker** | 110 | 1 | 6 | **7** | **14.2%** |
| **Mental Health Director** | 110 | 0 | 1 | **1** | **0.0%** |
| **Art Therapist** | 110 | 0 | 3 | **3** | **25%** |
| **MHS** | 110 | 4 | 66 | **70** | **5.7%** |
| **Administrative Assistant** | 110 | 0 | 1 | **1** | **0.0%** |

| | | | | | |
|---|---|---|---|---|---|
| **Locums Psychiatrist** | | | 2 | **2** | **0.0%** |
| **Locums Medical Assistant** | | | 2 | **2** | **0.0%** |
| **TOTAL** | | **17** | | **119** | **14.2%** |

*Of note that the MHS vacancy rate calculations do not include the 14 additional positions just added for the 2017 FE. These positions have been posted in January. Recruitment efforts are ongoing.

**Full Time Equivalents for Psychiatry and Psychology.**

**FTE's Psychiatry April 2017**

| | | |
|---|---|---|
| Chair (1) | 1.0 | (Kelner) |
| Attending Psychiatrists | 10.8 | (Advani, Howard, Marri 0.8, Menezes, Paschos, Ward, Bednarz, McNeal, Haq, Miller, Kartan) |
| Psychiatric PA (2) | 2.0 | (Balawender, Greiner) |
| Psychiatrists (133 acct) | 1.0 | (Lassen, Chinweze, Ramic) |
| Consulting Psychiatrist | 0.3 | (Binius) |
| Psychiatrist Locums | 1.0 | (Garb, Pandit) |
| Total Functional FTE | ***16.1*** | |

**FTE's Psychologists April 2017**

| | | |
|---|---|---|
| Chief Psychologist (1) | 1.0 | (K. Key) |
| Psychologists (10) | 7.0 | (Briney, Kaniuk, Waxler, Sillitti, Nunez, Augustine, Butler) |
| Total Functional FTE | ***8.0*** | |

As of April 2017 **Functional Vacancy Rate (FVR)**: # of fulltime positions/FTE's – # filled full time positions/FTE's – hours paid Acct. 133 ( part time) - hours paid Acct. 155( part time) - hours paid vendors( Locums) – hours paid overtime/moonlight – supplement by mgmt. =**1.8%**

If Physician Assistant Positions/FTE's are factored in – FVR in January 2017 is in the negative territory.

OT/Locums represent 1.1 FTE

**Psychiatry Allocations.**

Direct service hours and participation in MDT meetings constitute 100% of FTE's hours.

**Mental Health Staffing -April 2017**

| | | Apr-17 |
|---|---|---|
| **PSYCHIATRY** | | |
| **Psychiatric Special Care Units** | | |
| **Psychiatry Allocations:** | | FTE |
| 2 North: 3 Psychiatrist+PA with 7-day Coverage(RFX1.7) | | 3.3 |
| 2 South/Southeast: 2 Psychiatrist with 5-day Coverage | | 0.9 |
| 2 West: 2 Psychiatrists with 7 day coverage(RFX1.7) | | 1.7 |
| 2 E: 1 Psychiatrist Once a month coverage | | 0.1 |
| | **Total** | [redacted] |
| Physician /patient ratio on acute units> 1:15 | | |
| Physician /patient ratio on subacute units> 1:30 | | |
| **Divisions with P2Housing/OutPatient** | | |
| **Psychiatry Allocations:** | | |
| 920 daily average population in Min /Med Security Divisions ( II,IV,VI) | | 2.4 |
| 500 daily average detainees in Maximum security Divisions X and IX | | 2.1 |
| 175 daily average detainees in SMU ( Division IV,VI,IX,X)are absorbed into P2 population | | |
| | **Total** | [redacted] |
| **Residential Treatment Unit** | | |
| **Psychiatry Allocations:** | | |
| Absorbs SMU P3 and P2 Populations( daily average 18) | | 0.1 |
| Absorbes Intensive Management Unit ( average daily census 6 ) | | 0.1 |
| Male and Female(average daily population is 400 P3 and 190 P2)* | | 4 |
| | **Total** | [redacted] |
| NOTE:*RTU P2 population is concentrated on the 2nd,3rd and 5th floors and is absorbed by Psychiatry staffing | | |
| Physician/Patient ratio 1:147 | | |
| **RCDC** | | |
| **Psychiatry Allocations** | | |
| Monday, Tuesday, Wednesday,Thursday, Friday** | | |
| | **Total** | [redacted] |
| **Grand Total FTE** (Psychiatrists, Psychiatric PA, Consulting/Locums) | | [redacted] |
| NOTE:* RCDC has shortened shifts- 5hours | | |
| NOTE:** 2 Psychiatrists (1 for Male RCDC, 1 for Female RCDC) | | |
| 1FTE onsite hours =52 weeks=2080hours per year | | |
| Chief Psychiatrist provides no direct service hours | | |
| Psychiatrists do not perform administartive duties | | |

## Staffing Summary for Psychiatry:

- The main task remains attracting full time Correctional Psychiatrists through assertive national search and advertisement campaigns.

- One Psychiatrist transitioned from a Part time to Full time position. Another Psychiatrist was hired.

- 2 part-time Psychiatrists vacancies now exist (one Psychiatrist resigned and one converted to the Full Time Status). The majority of part-time (Account 133) Psychiatrists are committed to working between 8 and 20 direct service hours. There is one filled position of a Consulting Psychiatrist. The rate of compensation for this position has been made sufficiently attractive.

- Recruitment in progress: One FT Candidate has been credentialed and has estimated starting date in August ( finishing Forensic Fellowship); two other FT candidates are in Credentialing; one Candidate in Credentialing for the Consulting Position

- Telepsychiatry has been expanded on the compound and, in addition to flex time arrangements, continues to be an important recruitment and retention instrument. Telepsychiatry clinics function successfully in RCDC, Divisions VI, D2D, and X. The rate limiting step in the expansion of Telepsychiatry remains the availability of Telepsychiatry Clinic Attendants. Presently two Locums Attendants are working on campus.

- One additional Physician Assistant has been hired. Now 2 Physician Assistants are employed. Two MH PA's exceed Departmental expectations in terms of productivity and quality. As a point of reference, PCC employs 18 PA's and has zero vacancy rate for PA's. As a future direction, Chief of Psychiatry collaborates with Cermak CCO to augment current staffing with Pharm. D's and potentially expand the lines of services where PA's are deployed.

- A position of the Associate Director of Correctional Psychiatry was posted in February 2017

- Cermak has contracts with 4 (three) staffing agencies to provide Locum Tenens Psychiatrists: Medical Doctor Associates (MDA), Maxim Physicians Resources, Columbus Organization, and Regroup. All Vendors' contracts have Amendments for Telepsychiatry. Dr. Garb, furnished by Columbus, is deployed on site at Cermak in Division X. Dr. Pandit (Maxim) provides direct service hours in Division X as a Telepsychiatrist. The contracts for the three locum tenens agencies have been extended into 2017. Based on present clinical needs and recruitment yield, Cermak Mental Health Department projects that we will continue to need staffing assistance. Some of the Locums Psychiatrists who are currently in the credentialing process did not complete it. One Locums Provider decided not to pursue this position after the first two weeks of Orientation. Another Vendor (ReGroup) was added to the previously active Vendors. They specifically contracted to provide Telepsychiatrists and not on site personnel. Two

Locums Medical Assistants perform as Telepsychiatry Clinic Attenddants while CCHS is exploring how to create en employed position of the Medical Assistant.

- Ongoing current advertisement efforts by CCHHS involved postings in industry publications, including the AAPL quarterly letter, communication with the local feeder schools, and participation in local Psychiatry Fairs (October 2016).

- Additional staff hired in the CCHHS's Credentialing office will provide for increased support to engage applicants and expedite processing.

- "Advanced Clinical Process (ACP)" at Cermak has been in place since November 2015. The Advanced Clinical Process was created to assist Cermak in filling hard to fill credentialed positions. The ACP process has helped enhance the recruitment process by allowing for the participation of departments to solicit candidates to submit resumes / CVOs to a centralized mailbox, which allows for the expedited review and determination of candidates meeting minimum requirements. Due to success of this pilot, the ACP process is now implemented CCHHS wide.

- As an important recruitment tool Cermak Psychiatry continues to support student and Psychiatry residents' rotations/training on site from nearby medical schools (Rush+ UIC's).

**RTU staffing.**

| | RTU 5th floor females | RTU 4th floor(+ 2nd and 3rd floors) |
|---|---|---|
| Psychiatrist | 1.0 | 3.0 |
| Psychologist/Unit Director | 1.0 | 1.0 |
| Social workers | 1.5+ 1.0 Expressive therapist | 1.5+1.0 Expressive therapist |
| Mental Health Specialists (cover RTU 5th floor and Div. 4 for female services) | 3 MHS III in am<br>2 MHS III + 2 MHS II in pm | 3 MHS III + 3 MHS II on AM<br>4 MHS III's on PM |
| Population as of 3/31/2017 | P3 87 P2 41 ( 128) | P3 286 P2 107 (393) |

***Staffing Levels vs Practice Patterns discussion***: Information obtained during previous visits suggested that the amount of time allotted to initial psychiatric examinations was insufficient to conduct thorough initial evaluations, conduct medical records review, and enter documentation

in EMR. To address the above concerns a number of measures were developed.

- A scheduling Pilot in Division VI started in Division VI. It allots 40 minutes for an Initial Assessment and 20 minutes for follow up sessions. CQI will be performed to assess the results and whether or not the above metrics will be positively affected by having increased time allotments.
- The Access to Care Collaborative DOC/Cermak Pilot is under way in Division IX. It automated communications related to patient movement, likely to increase movement to clinic efficiency, and flush out if detainees are brought to clinics at uneven intervals, thus, increasing demands on Providers at some times and making them idle during extended periods of time, if most of the patients are brought to the clinics before their closure. Patient movement to clinics is, at times, impeded in high security and special management areas, and those factors will be examined further through CQI studies.
- Clinical Performance and Enhancement Peer Review Process was developed by the Chief of Psychiatry and the CQI study allowed to identify some outliers in terms of their adherence to safe practices. The results of the secondary analysis indicated that Providers who did not adhere to the standards of evaluation and documentation in many cases did have sufficient time to meet expectations and further in training and individual supervision will be used as corrective interventions. Relevant CQI study is available in the PDF Appendix.
- Following extensive chart reviews, JSH IT assisted in creating the following efficiencies with EMR:

    a. Mandatory Fields were added to CHS Mental Health Notes designed for Initial Evaluation. They included history of present illness, prior psychiatric history, family history, psychosocial/legal history, and Brief Psychiatric Review of Systems. It will be impossible to close out notes without charting in those sections. The attestation functionality by a Physician permitting them to log how much time was expanded on direct patient face to face care. Further studies will be conducted using functionality to assess Providers' self-report against what Cerner registers ( EMR is able to pull the data on how much time notes were opened during each patient contact).
    b. A Note was modified to replace existing Psychiatry Follow up EMR note to further increase the efficiency of documentation. That notes contains the attestation functionality by a Physician permitting them to log how much time was expanded on direct patient face to face care. It is understood that in the correctional milieu the amount of waiting time can significantly affect clinical productivity and, yet, the System does not allow Providers across CCHHS to document waiting time based on prior best practices and precedents.
    c. As elsewhere discussed, a new Master Treatment Plan template was introduced for P2 populations. The results of chart audit are discussed in the section dedicated to treatment plans.

- Frequency of contact with Providers study was undertaken in all the Levels of Care to address concerns that patients are dealing with unreasonably high waiting times. The results of this CQI study are available in the PDF Appendix.
- Discharge planning issues, especially as it relates to Psychiatry discharges in high turnover minimum security areas, have been discussed with DOC. It was decided that post discharge follow up issues had to be addressed in a centralized fashion in order to avoid confusion inherent in the scenarios when different instructions are given by multiple parties. CCDOC Department of Inmate Services, with the input from Cermak, developed a comprehensive Inmate's handbook where post discharge and follow up issues will be addressed in the Handbook's second addition in 4/2017. The audio broadcast containing Handbook information overview in its entirety is received by every living Unit during Sunday and Wednesday broadcasts. Living Units are encouraged to broadcast this information as frequently as they want to. Additionally, discharge issues and post-discharge linkage are extensively discussed by MSW with patients. Relevant CQI study for post-discharge linkage available in the PDF Appendix.

**Summary for Psychology:** There is a total of 10.0 FTE psychologist positions (excluding the Chief Psychologist position) with a current vacancy rate of 30% (3 FTE). Cermak has lost several candidates in later stages of their hiring process due to the fact that their internships were not APA approved. Efforts are made to vet candidates early on to identify candidates whose internships would disqualify them from receiving clinical privileges at Cermak. Furthermore, Cermak MH Leadership is working with the CCHHS Credentialing Committee to modify presently existing minimum job criteria from having APA certified predoctoral internship to the APPIC accredited training. The language and research were submitted to the Credentialing Committee. Resolution is pending. This step is designed to expand the pool of prospective candidates, while deferring to MH Leadership to vet deserving candidates and further strengthening the post-hiring Professional Evaluation Process.

For FY 2017, Cermak has submitted a request to fund 2 post-doctoral Psychology Fellows to work under the supervision of the Chief of Psychology, to provide diagnostic assessment, crisis intervention, intake evaluations, group and individual therapy, consultation with multidisciplinary treatment team, projective and objective psychological testing, security and civilian staff training, and supervision of practicum students.

There is a total of 70 MHS Specialist Positions with a current vacancy rate of 5.7 %. There are those who are presently enrolled in a Master's program and expected to be eventually licensed. They will be expected to complete their degree/licensure by specific, individualized dates (based on current status and anticipated licensure date).The ones who have matriculated Master's Programs and obtained licensure are being promoted into MHS III Positions. If these employees do not achieve licensure by their specified dates, their position will be eliminated. The first rounds of separations took place in July 2016. Presently, licensed staff (as they meet their educational and licensure requirements) is being promoted to fill positions vacated by the unlicensed staff.

At the start of the fiscal year Cermak received support for 14 new Mental Health Specialist III positions and 1 Activity Therapist. Most of the MH positions have been posted. Interviews are ongoing.

In November 2016, the Cermak MH department undertook a comprehensive review of its staffing and staff productivity, including the average number of hours of group treatment provided to detainees housed in P3/Intermediate housing units and the number of scheduled groups, clinics or other services cancelled due to a lack of staff. The review focused on services delivered by Mental Health Specialists. The department created a multifaceted approach to increase the number and quality of services, including strictly enforcing the time and attendance policy, requiring that staff provide at least two-weeks notice for all planned time off, increasing clinical supervision for staff whose productivity was low compared to other employees with comparable duties, imposing disciplinary action for employees found to misrepresent their productivity or who cancelled services inappropriately, establishing minimal critical staffing levels for all clinical areas and pursuing an agreement with the union representing the MH specialists to mandate overtime.

Beginning with February 2017, the department began to mandate OT for planned absences and, beginning in mid-March 2017, for staff call ins. Staff are required to provide a minimum of 2 hours' notice when they call off work.

When an employee calls off, MH leadership sends out a group email to all MH Specialists III staff requesting volunteers to cover the post. If no volunteers are found and the post is considered critical, employees on the campus are mandated to cover the post.

There is a total of 6 Medical Social Workers Positions. 6 positions have been filled.

The mental health staff vacancy rate is 14.2%.

Positions of the Chief of Psychiatry, Chief Psychologist and Mental Health Director are filled.

**April 2017 Metzner assessment:** The functional vacancy rate for the psychiatrists appears to be the lowest since the implementation of the Agreed Order. When allocated part-time and consulting psychiatrists' positions are translated in terms of FTEs, and psychiatric physician's assistant FTE positions are included, Cermak has approved funding for about 20 FTE line staff psychiatric provider positions in contrast to the 15.0 FTE line psychiatric positions described in the staffing summary from 2014. It appears that 3.0 FTE psychiatrists will be hired by August 2017.

It is my recommendation that 1.0 FTE of the anticipated 3.0 FTE psychiatrist new hires be allocated to the RTU in order to cover any P2 inmate residing in the RTU as well as covering the IMU and RTU SMU. This would reduce the psychiatrist: P3 staffing ratios to a more acceptable level. Increasing the psychiatrists' allocations to the compound P2 population by 1.0 FTE

psychiatrist would decrease the psychiatrist: inmate patient ratio from 1:346 to 1:290. Adding 2.0 FTE psychiatrists would decrease the psychiatrist: inmate patient ratio to 1:246, which would be an acceptable staffing allocation.

QI studies indicated that psychiatrists were frequently assessing/evaluating caseload inmates (both P2 and P3) with a frequency greater than the minimum required intervals. P3 inmates reported that they were generally seen on a monthly basis by a psychiatrist.

A targeted random sampling of 13 CCDOC detainee charts was reviewed jointly with Dr. Kelner with parameters of those who received a "P2" assignment between November 2016 and February 2017. Findings of this chart review indicated overall the initial psychiatric evaluation was completed within 14 days of the screening; many of the initial evaluations were completed within seven days of referral. The quality of the psychiatric assessments varied. Focused clinical assessments predominated as opposed to comprehensive initial evaluations. Diagnostic assessments were generally adequate, though at times, prior diagnoses were continued without any clinical documentation supporting the diagnosis. The prescribed medications were congruent and appropriate to the listed condition. There were only a few cases in which limited indication was documented as to why a particular medication was prescribed. Few detainees were prescribed medications such as mood stabilizers that necessitated screening and follow up blood work. Of these, one had a Depakote level ordered in an appropriate time-frame, but no other lab work. A second had appropriate pre-screening and follow up labs.

Another 8 CCDOC detainee charts was reviewed jointly with Dr. Kelner with parameters of those who received a "P3" assignment between November 2016 and February 2017. Findings of these chart reviews indicated that the majority of the patients were seen in a timely manner, some seen within several hours of initial intake screening. Overall, the psychiatric assessments were thorough with appropriate diagnostic clarity with congruent treatment plans. The main problem area identified in chart review was with detainees assigned to the intermediate care "overflow" units. The initial psychiatric assessment tended to be delayed beyond the anticipated timeframe. In particular, one detainee with serious mental illness was not evaluated by a psychiatrist for five weeks after initial screening. However, this pattern of overflow detainees had already been identified by Cermak staff, and it has reportedly been rectified by assigning a psychiatrist to specifically cover the "overflow" unit, along with a printed list of each "P3" detainees in the units to review at staffing. Overall, the follow up psychiatric evaluations were performed in a timely manner based on clinical necessity with only a few exceptions. Only one detainee was prescribed medications while in intermediate care that mandated lab work, which was performed appropriately.

Follow up appointments for the P2 detainees were also generally appropriate, with a time frame of four to twelve weeks depending on clinical scenario. In one case, a detainee was prescribed three psychotropic medications, but he was lost to follow up upon transfer to different divisions. He did not receive a psychiatric follow up prior to discharge from the jail within the requested appointment timeframe.

**Recommendations:** As above.

**g. Cermak shall ensure timely provision of therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming. Cermak will develop and implement policies and procedures defining the various levels of care and identifying the space, staffing, and programming that are appropriate to each identified level of care.**

**Compliance Assessment:** Substantial compliance (4/17)

**Factual Findings:**

**April 2017 Cermak Status Update**

Please see Update in 59f.

**April 2017 Metzner assessment:** See Update in 59f. The substantial compliance finding is based on the assumption that the recently allocated 14.0 FTE mental health specialists' positions will be filled in a reasonable period of time, and as well as the psychiatrists' and psychologists' vacancies.

**Recommendations:** Continue the aggressive recruiting and hiring process.

**h. Inmates shall have access to appropriate infirmary psychiatric care when clinically appropriate.**

**Compliance Assessment:** Substantial compliance (11/16)

**Factual Findings:**

**April 2017 Cermak Status Update**

***Cermak Male Acute, Subacute and Chronic Mental Health Unit Descriptions***

The Cermak male psychiatric units are comprised of 60 beds distributed among 3 units – 2North (acute unit), 2South (subacute unit) and 2East (chronic unit). The purpose of the units is to provide extended observation, stabilization and structured/unstructured therapeutic activities. Services are provided by a multidisciplinary team, which includes psychology, psychiatry, mental health specialists, nursing, social workers, correctional rehabilitation workers and custody staff.

Male detainees may be admitted to 2North, the 24-bed acute psychiatric unit, from intake, general population or other mental health units. Primary reasons for admission include an acute risk for harm to self or others, acute psychosis, and an inability to care for self or marked decompensation that poses as a risk for victimization in other living units. Detainees housed on 2North are scheduled to see a psychiatrist 5-7 times per week. Detainees are typically housed on 2North for a brief period of time before transitioning to a less restrictive setting.

The subacute mental health unit, 2South, is a 26-bed unit for detainees that have demonstrated a decrease in the severity of psychiatric symptoms but continue to evidence symptoms that cannot safely and adequately be treated in a division with mental health services. Some detainees exhibit chronically severe symptoms that necessitate long term sheltered housing. They may be housed on 2South or 2East, a 12-bed unit that houses detainees that demonstrate severe negative symptoms of psychosis, chronically severe depression and/or significant cognitive delays.

2S/2SE concentrates the most recalcitrant and treatment refractory detainees with serious mental illness on the compound. In order to preserve a safe, sanitary, and therapeutic milieu in the area where adherence to hygiene and personal self-care is often a challenge for many of those detainees, Cermak MH, Environmental Services, and DOC staff collaborate in maintaining:

1. Cleaning schedule- twice a day (am and pm) including the weekends on both 2S and 2SE. The pm cleaning is for selected cells that need extra attention. Power washing frequency is to be determined. Supt. Hays is asked to provide staff to assist the cleaning of 2S/2SE.
2. Additionally, DFM Plumbing foreman have been requested to have a plumber come to 2S/2SE every morning Monday through Friday.
3. DOC avoids, if possible, feeding detainees in their cells, when practicable, in order to minimize the resurgence of fruit flies' population.
4. " Humanitarian showers" on the 3-11Pm shift are available as needed in close coordination between DOC, PCS, MHS, and Psychiatry. MH will submit the lists of detainees requiring hygiene to Supt. Hayes and Shift Commanders. MH will secure OT, if need be, to assist in coordinated preplanned hygiene.
5. Cleaning and environmental maintenance should not interfere with ongoing out of cell therapeutic programming.

**CCDOC Update:**

**2North/2South/2West/2East**

The General Population detainees/patients receive time out of cell for a minimum of 8 hours per day, though most days exceed 10 hours of out of cell time. Problematic detainees that require time out of cell alone receive 2-3 hours out of cell each day depending on their behavior. These detainees receive out of cell time in an area separate from the general dayroom area. Units 2North, 2West and 2South have all been retrofitted to include a contained area for such

problematic detainees to recreate outside of his/her room while dayroom activities continue for the larger population. Protective Custody detainees are encouraged to participate in programming for additional hours out of cell.

***Cermak Detainee Hygiene***

DOC, nursing, environmental services and mental health staff continue to be proactive with managing inmates with poor hygiene in Cermak. Once a humanitarian shower is requested, all staff work together to accomplish the task.

The Sheriff's Office worked collaboratively with the Illinois Department of Human Services to draft a bill that would reduce the amount of time it takes to transfer a detainee to a state forensic hospital after a finding that he/she is unfit to stand trial or not guilty by reason of insanity. As a result of the Sheriff's Office advocacy, the number of individuals awaiting transfer to DHS and the amount of time it takes to transfer has been greatly reduced thereby positively impacting the Cermak census.

***Recreation:*** Detainees in Division 08 RTU have access to recreation on the patio and in the indoor and outdoor recreational spaces of other divisions. The detainees are offered access to recreation 3-5 times weekly. In the month of March, detainees housed on the 4th floor of RTU were provided access to recreation an average of thirteen (13) times. Detainees housed on the 5th floor of RTU were provided access to recreation an average of seventeen (17) times. The DOC has been working diligently with our County partners to winterize the RTU patios in 2017. The 4th and 5th floor patios are expected to be winterized by the Fall of 2017.

Recreation is offered to Cermak 2nd floor detainees at least twice weekly in the 3rd floor recreational space. Detainees often refused to participate in off-tier recreation due to the lack of a television and instead elected to spend their recreation time in the dayroom of the living unit. The Cermak Superintendent recently secured a television for the recreation room. Additionally, the Cermak recreational space is equipped with a ping pong table, bag toss games and board games.

***Cermak Female Acute and Chronic Mental Health Unit Description***

The Cermak female acute and chronic mental health unit, 2West, is a 20-bed unit devoted to the psychiatric stabilization of detainees whose presentation warrant stabilization and/or extended observation. Detainees may be admitted to 2West from intake, general population or other mental health units. Primary reasons for admission include an acute risk for harm to self or others, acute psychosis, and an inability to care for self or marked decompensation that poses as a risk for victimization in other living units. Detainees housed on 2West are scheduled to see a psychiatrist 5-7 times per week. Detainees are typically housed on 2West for a brief period of time before transitioning to a less restrictive setting unless they present with symptoms that warrant chronic care services. Chronically mentally ill detainees that require continued housing

on 2West demonstrate severe negative symptoms of psychosis, chronically severe depression and/or significant cognitive delays that cannot safely and adequately be treated in a division with mental health services.

According to the Interagency PSCU Policy, bed assignment is a collaborative task between DOC, Nursing, and Mental Health. Striving to maintain the integrity of ongoing out of cell structured therapeutic programming and recognizing the importance of having dayroom available for therapeutic programming, Cermak supports using every appropriate space/accommodation for patients in need of single rooms, including, but not limited to:

- Temporarily holding 2N detainees on 2S and 2E. When there is a new admission(more unstable) to 2N in need of a single room, more stable 2N patients occupying a single room may be transferred to 2S and 2E on a temporary basis.
- Using existing single rooms on 2N (putting new detainees in need of single room in the rooms of established (stable) single room patients who are having their "hour" out).
- Using group rooms (when group room detainees are out for therapeutic and unstructured activities) to temporarily insert new admissions in.
- Temporarily keeping new detainees in other appropriate clinical/non clinical space on 2N (for instance, the long hallway and the small group room). DOC is requested to provide direct observation of these detainees if they are kept in clinical areas.
- Keeping new detainees who need a single room in the big dayroom will be used only as the last resort.

Providers, Unit Directors, and MHS will collaborate with DOC Supervisors and front line staff identifying accommodations designed to avoid any disruption in therapeutic programming.

Psychiatric coverage of the Psychiatric Special Care Units has been largely unchanged: 2N is covered by 3 Psychiatrists and 1 Psychiatric PA (Balawender. 2W covered by 2 Psychiatrist. 2S/2SE is covered by two Psychiatrists. 2E is covered by on Psychiatrists. All the Psychiatrists combine PSCU coverage with some divisional clinics. Section 59f. has detailed descriptions of Psychiatric allocations within the PSC Units. Please see PDF Appendix for QI related to frequency of contact of PSCU patients. Two Psychologists are dedicated to PSCU: one being a Unit Director for 2N/2W and the other for 2/2SE/2E.

**2 North & 2 West Updates**

2N (males) and 2W (females) are the Psychiatric Special Care Units within Cermak Health Services that provide psychiatric/mental health services to a population of acute, sub-acute, and chronic individuals. A psychiatrist meets with each patient within 24-hours of admission and then daily thereafter. Structured group programming is delivered daily to patients, which range from a "Rise and Shine" group focusing on hygiene/ADLs, to "Community Meeting/Unit Orientation," as well as more clinically focused groups such as "Grief/Loss Group" and "Community Reintegration." Patients on PSCU have access to a Mental Health Specialist III

(licensed clinical staff) 24-hours a day, 7 days a week. Structured programming is delivered 7 days a week on both the 7-3 and 3-11 shifts.

**Programming**

Clinical groups take place both in the day room and in the small group room and generally engage patients in discussing topics such as Anger Management, Coping Skills, Patient Rights, Understanding Mental Illness, etc. Dayroom hours and structured programming are calculated most closely on the 2 North Unit. Through an interagency directive, both dayroom hours and programming hours have been increased on 2 North and 2 West.

Patients housed on the Special Care Units are seen by a Mental Health Specialist during rounds on each shift, and they have access to a licensed Mental Health Specialist 24 hours a day. Patients are engaged in the milieu (dayroom or interview room) or cell front if necessary for security or clinical reasons. Patients also have access to psychiatric services while housed on the Special Care Unit. They typically meet with a psychiatrist or physician's assistant up to daily while acute status or up to 5 days weekly if not.

A QI Project was initiated in May 2016 to ensure the accuracy of the reported dayroom hours. The QI entitled "Cermak Dayroom Hours" provides detailed information comparing the hours recorded by Mental Health staff with video footage of the dayrooms on 2N and 2W. The unit schedules aspire to provide 12 hours of open dayroom time every day where patients have access to care and are provided with 8 hours of structured programming. The interagency unit schedule is attached to the associate QI reports in the Appendix.

Group programming hours on 2N and 2W have remained consistently high over the last six months (Appendix). One factor that has contributed to increased consistency with regards to group programming hours is the decrease in group cancellations. The Mental Health department has worked with CCDOC leadership to decrease and/or prevent groups from being cancelled. This has increased access to care in terms of psychiatry, nursing, as well as group programming. Several approaches/solutions have been implemented to prevent dayroom closure including: 1) placing a newly admitted patient who requires a single cell in a room while group takes place and then after the dayroom hours return the patient to the dayroom, 2) placing the patient in the back hallway in a chair or "boat" bed and provide security supervision, and 3) boarding more stable patients on other second floor units if there is available space.

There has also been an effort to increase programming offered in the small group room. This provides increased confidentiality and a more intimate setting for patients to engage in group therapy. A QI project was initiated in November and the results of that study will be presented in a separate CQI report entitled "CQI Small Group Room Programming." The results of this study suggest that there is still progress that needs to be made in terms of increasing the percentage of groups that take place in the small group rooms (Appendix).

**Treatment Planning**

An area of improvement that was identified during the last audit was treatment plan development, review, and update. Procedures have been initiated on both 2 North and 2 West to ensure that treatment plans are updated within the specified timeframes of our policies. The "Treatment Plan CQI" looks at treatment plans for P4's during the month of December. The overall compliance percentage of 92% (up from 81% in October 2016) suggests that consistency has been maintained in terms of the development, review, and updating of treatment plans. The quality and effectiveness of the treatment plan should be assessed moving forward. Outcome studies may help to better understand the impact our services have on our patients' mental health and wellbeing. The treatment plan audit and summary will be provided in a separate Appendix document analyzing treatment plans across the department.

**Additional Activities**

In addition to providing assessment/treatment planning, milieu therapy, rounds, individual sessions, and group sessions, the mental health staff also meets daily in a "morning huddle" to discuss new admissions and any concerns or questions from the previous day(s). Staff will also regularly engage in multidisciplinary treatment team meetings held twice a week on both units to discuss patient progress, update the patients' treatment plan, and address any other pertinent items/issues. The restraint and seclusion log for the previous week is reviewed twice weekly (am and pm shifts) at staffing, and staff is given the opportunity to discuss any issues or questions they have with the process of utilizing therapeutic restraint/seclusion. Multidisciplinary Treatment Team (MDT) meetings are scheduled regularly and invited parties include psychiatrists, psychologists, physician's assistants, mental health specialists, nurses, and correctional officers.

With regards to the milieu and therapeutic environment on the psychiatric special care units, staff work towards developing rapport with each patient and providing a sense of physical and emotional safety. This is especially the case on 2 West (females), where staff provides a more trauma-informed approach to working with patients. Staff encourages patient compliance with treatment while also respecting patients' rights. Mental health staff spends time describing patient rights with regards to medical/mental health treatments (i.e. right to refuse medications). The incentive program is utilized on 2 West to encourage patients to participate in health-promoting activities, such as hygiene, group therapy, and medication compliance. Mental health staff tallies points and provides incentives for patients who engage in these activities. Mental health staff will modify the incentive program for patients with special circumstances (such as out alone/house alone status) to make it possible for all patients to participate in the program. An area that has been improving is cooperation/collaboration across disciplines. This has traditionally been a challenge, but has been moving in a positive direction. Mental health specialists are more likely to communicate/collaborate with medical, nursing, and the officers. This collaboration can be challenging at times due to discrepancies between professional perspectives and opinions, but has been improving. The increased collaboration amongst leadership may be driving this improvement (i.e. regular interagency management meeting and

multidisciplinary staffing). We will continue to hold multidisciplinary clinical staffings to ensure that all disciplines are represented and that all varying perspectives are taken into account.

**Areas for Improvement**

The key areas identified for improvement during the last reporting period (October 2016) were:

1. Monitor dayroom closures more closely and develop interagency procedures to prevent dayroom closures – There has been a decrease in dayroom closures on the past six months (see programming statistics).
2. Increase small group room programming by scheduling one small group per clinician per week- This continues to be an area for improvement according to the Small Group Programming CQI. Staff will be scheduled to provide one at least small group per week.
3. Continue to encourage CCDOC attendance/participation at clinical staffings- CCDOC staff has been more present at clinical staffings/MDT. Mental health patient care is also a standing item that is discussed at the weekly interagency management meeting.
4. Continue to monitor compliance with treatment plan policy- There has been continued improvement in this area and procedures will continue to be implemented and reviewed to ensure that treatment plans are reviewed in a timely manner (in accordance with policy) and that the patient is informed of the plan and/or participated in developing the plan.

Improvement areas for this reporting period:

1. Increase small group room programming by mandating that each mental health specialist assigned to each special care unit (2N and 2W) provide one small group per week.
2. Continue to develop procedures to ensure patients are informed of their treatment plan and that the plans are updated within the specified timeframes.
3. Continue to regularly evaluate group quality through conducting random structured evaluations and providing feedback to mental health staff.

**2 South/east & 2 East Updates:**

The 2 South offers up to eight hours of structured group programming and unstructured dayroom activity per day, seven days per week. Because of a staffing shortage, 2 East currently offers dayshift group programming only; additional staff are in the process of being hired currently for evening shift. 2 Southeast does not currently offer separate programming with the exception of expressive art therapy. Patients who are able to participate in group programming and milieu activities join these events on 2 South. 2 Southeast patients who are not able to tolerate the stimulation of group activity are given individual time out alone or in twos or threes. Some patients require restraint when in the dayroom to ensure safety of others. These patients are brought out only with other individually restrained patients.

Programming includes daily 'Rise and Shine' group, a morning hygiene group, Community Meeting, Medication Management Group, Coping Skills, Anger Management, Current Events,

Art Therapy, and Community Reintegration, Chair Yoga, and other topics. Daily scheduling of programming follows the same timeframe as that of 2 North and 2 West. As on 2 West, all three male units utilize the incentive program to promote to participation in hygiene, group programming, and compliance with medications.

**Developments in the Last 6 Months**

1. Separating 2 Southeast from 2 South has helped promote a more therapeutic milieu on both units. More aggressive and disruptive patients have been better managed in the smaller, less stimulating environment of 2 Southeast. In addition, modifications have been made to the physical plant to promote safety. Aggressive, highly impulsive patients can spend more time out-of-cell with the installation of secured television sets and secured 'watching stations' in the dayroom. 2 South patients are able to participate in programming with reduced risk of disruptive, aggressive, or predatory behavior by more severely impaired, treatment-refusing individuals.
2. There has been a strong effort by Psychiatry to increase the number of cases petitioned for involuntary court-ordered medications.

3. Recent hiring of additional psychiatrists have increased coverage by attendings on these units, promoting improved quality of care. In addition, recent approval of additional Mental Health Specialist positions is expected to provide coverage on 2 East for evening shift and reduce the need to 'pull' staff to provide needed coverage when staff members call in sick.

4. Recent enhancements to the units include the trial use of tamper and ligature resistant sprinkler heads in the patient rooms. A nagging design flaw in Cermak has been the use of exposed sprinkler heads, which are relatively easy to break, causing major flooding. Several times a year, the units become flooded as a result of patient tampering, causing water to leak through the ceiling and damage administrative offices on the first floor. It is anticipated that all rooms will be refitted with these new and safer sprinkler heads over time.

5. In conjunction with Ms. Lonna Speer, inventor of the safety smock, our staff has been working with her company, Ferguson Safety Products, to design a safety jumpsuit which looks 'less like a dress', and is more dignified, durable, and tamper resistant. We have used several prototypes with our patients to beneficial effect. In addition, beds on the units are being replaced by newer and safer 'moduform' beds.

6. With these improvements in staffing and the physical milieu, there have been increases in programming hours, staff and patient safety, and successful management of the most severely mentally ill patients in the CCDOC system. This has meant that patients can be maintained in Cermak with less movement off-tier due to extreme disruptive and aggressive behavior. In conjunction with increasing the number of patients petitioned for

involuntary court ordered medications, it is anticipated that we will be more successful in managing and stabilizing our most challenging patients.

**Medical Social Work: Discharge Planning**

The Cermak PSCU is staffed with 2 Medical Social Workers who maintain regular contact with detainees diagnosed with serious mental illness to coordinate post-release treatment services in the community. Due to the severity of their mental illness, all detainees released to the community from PSCU must be assessed by a Qualified Mental Health Professional prior to discharge to determine the need for hospitalization. If community hospitalization is not warranted based on the clinical assessment, the Medical Social Worker can assist the detainee with referrals to community agencies for continued treatment and shelters for housing. The Medical Social Worker can also arrange for the detainee to be given a prescription for discharge medications. Please refer to Appendix for QI related to discharge planning at all levels of care.

One new and exciting resource available to the MSW staff is the CCHHS Community Triage Center (CTC). The CCHHS Community Triage Center is one tactic we are implementing to address the overwhelming lack of behavioral health care services across our region. Patients released within short time frames or prior to completion of a comprehensive discharge plan can be referred to the CTC for a "soft hand-off" after release. The CTC staff can serve as a touch point in the community for a detainee upon release to make sure he or she can continue keep their behavioral health condition controlled outside of a the jail environment. The CTC will be additionally useful as a case management resources when Cermak medical social workers arrange community linkage to discharged patients; however the agencies are often closed for the day by the time the patients are discharged from the jail. The CTC will serve as an identified location that community agencies can connect with the patient's the following day.

CCHHS looked at the locations of the patients brought to its emergency departments with behavioral health conditions, as well as the home zip code of detainees with behavioral health conditions at the Cook County Jail to determine which area in the County was the most in need of community-based behavioral health services. Based on the data, the Roseland community was identified as one of the most underserved areas in this respect, which is why it was chosen as the location of CCHHS' first CTC.

The Medical Social Workers also continue to be an integral part of the response to calls received by the Sheriff's Care Line. All information related to mental health issues continues to be forwarded to the identified medical social workers for follow up and/or delegation to divisional social workers if indicated. Since the last visit, our social work staff has addressed 35 calls/referrals. Of those referrals, (66%) had already been identified, evaluated, placed on the MH caseload and were receiving treatment. (9%) of the referrals yielded new additions to the MH caseload or yielded information that Cermak providers did not yet have access to, and the remaining (25%) referrals were determined to not be in need of continued follow up from the MH department. This collaborative community outreach effort has resulted in increased access

to collateral information and opportunity for improved care and clarification of needs.

Detainees meeting criteria for involuntary admission by petition and certificate are transported to one of two area hospitals (Mt. Sinai and St. Anthony) upon release from Cermak by the court system. All detainees with P4 alert are evaluated at the moment of court release, and those anticipated to meet criteria for involuntary admission in the community are also 'flagged' ahead of time in EMR to ensure that their need for continued inpatient treatment is not overlooked if they are released in the overnight hours. There has been no indication of 'missed' evaluations at discharge recently, and the program continues to be efficient.

| *INVOLUNTARY HOSPITALIZATION BY PETITION & CERTIFICATE UPON RELEASE 2014-17* | | | | | |
|---|---|---|---|---|---|
| *YEAR* | *Q1* | Q2 | Q3 | *Q4* | *TOTAL* |
| *2017* | *16* | | | | *16* |
| *2016* | *10* | *13* | *11* | *15* | *49* |
| *2015* | *12* | *15* | *5* | *13* | *45* |
| *2014* | *12* | *13* | *11* | *11* | *47* |

Detainees meeting criteria for the administration of involuntary medications (non –emergency basis) continue to be evaluated for filing of the Petition. Some patients refuse to accept psychotropic medications, sometimes even in cases when their safety and survival depends on their receiving treatment. In those cases, judges are petitioned to authorize involuntary treatment. Typically our petitions for the administration of involuntary treatments are heard by the judges at the Circuit Court of Cook County. Cermak's petitions for the involuntary administration of psychotropic medications undergo vigorous judicial review and are not afforded the administrative review process. While preparing these petitions requires many hours of medical research and clinical data analysis, this painstaking process was made even more difficult by the fact that Psychiatric Providers have to travel to the Daley Center for the hearings. Following a Curcuit Court Resolution permitting the use of Teleequipment to conduct court hearings from remote sites, Circuit Court Judges began conducting hearing remotely, allowing respondents, lawyers, witnesses, and Psychiatrists to be present at the Leighton Center, thus greatly reducing Cermak's travel and time expenditures. Additionally, in order to improve efficiency and continuity of care between Department of Mental Health Facilities where detainees are remanded for the restoration of fitness, a reciprocal process has been developed, allowing for the modifications of Court Orders for Involuntary Medications ( non-emergency basis) to other counties when detainees leave CCDOC campus for DMH facilities and, conversely, detainees returning from DMH following the restoration of fitness have their court orders for involuntary medications "domesticated" to Cook County. The CCHHS Office of General Counsel has been greatly responsive to Cermak's needs and coordinated various aspects of the said process. The table before summarizes some of the recent trends.

| *Involuntary medications by court order( nonemergency basis) FILED/ORDERED [QUARTERLY 2014-17]* | | | | | |
|---|---|---|---|---|---|
| *YEAR* | *Q1* | *Q2* | *Q3* | *Q4* | *TOTAL* |
| *2017* | *6/3* | | | | *6/3* |
| *2016* | *3/2* | *1/1* | *3/3* | *7/6* | *14/12* |
| *2015* | *3/1* | *1/1* | *1/1* | *2/2* | *7/5* |
| *2014* | *1/1* | *2/1* | *1/1* | *2/2* | *6/5* |

Of 6 the orders sought, during 2017, 3 were granted, 1 was mooted by inmate discharge, 1 was denied, and 1 is still pending.

Cermak periodically updates CCDOC Leadership on complex management cases. CCDOC Leadership discusses these cases with ASA and the Office of PD Leadership trying to establish priorities in streamlining cases and coordination between multiple parties. Cermak PCC and MH files petitions for Guardianship, when needed. CCHHS Office of general Counsel assists in gathering information and setting up hearings.

CCSO facilitated sessions of Crisis Intervention Training (CIT) training for Cermak clinical staff and custody staff. Staff selected to attend reported finding the training extremely useful. There have been 4 full 40 hour classes and 1 one day training. Cermak's involvement is as follows:

13 unique staff completed the 1 day training (3 of those individuals are no longer with us).
34 unique staff completed the full 40 hour training (1 of those individuals is no longer with us).

**April 2017 Metzner assessment:** The significant improvements in the therapeutic milieu noted during the previous site assessment have been maintained as has the numbers of hours of structured out of cell therapeutic activities being offered to detainees in the PSCU.

During the afternoon of April 2 12, 2017 I observed a treatment planning meeting during the afternoon shift, which was attended by all the appropriate staff with very good multidisciplinary input. The psychiatric staffing allocations within the PSCU are very appropriate. Clinical staff observed were very competent in performing their tasks.

I also attended morning huddles foe Units 2W and 2N during the morning of April 13, 2017 and treatment team meetings for units 2N and 2S during the same day, which were all very well run.

i. **Cermak shall provide the designated CCDOC official responsible for inmate disciplinary hearings with the mental health caseload roster listing the inmates currently receiving mental health care.** (included in this appendix for formatting purposes only)

**Assessment:** Substantial compliance (since June 2012)

**j. When CCDOC alerts Cermak that an inmate is placed in lock down status for disciplinary reasons, a Qualified Mental Health Professional will review the disciplinary charges against inmate to determine the extent to which the charge was related to serious mental illness. The Qualified Mental Health Professional will make recommendations to CCDOC when an inmate's serious mental illness should be considered as a mitigating factor when punishment is imposed on an inmate with a serious mental illness and to minimize any deleterious effect of disciplinary measures on an inmate's mental health status.**

**Assessment:** Substantial compliance continues (since October 2012). (included in this appendix for formatting purposes only)

**Factual Findings:**

**April 2017 Metzner assessment:** Substantial compliance continues

**k. In the case of mentally ill inmates in segregation, CCDOC shall consult with Cermak to determine whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on Cermak's assessment.**

**l. Cermak shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals or by Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional, in order to assess the serious mental health needs of inmates in segregation. Inmates who are placed in segregation shall be evaluated within 24 hours of placement and thereafter regularly evaluated by a Qualified Mental Health Professional, or by a Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Cermak shall provide CCDOC with its recommendation regarding whether continued segregation is appropriate or whether the inmate would be appropriate for graduated alternative based on the assessment of the Qualified Mental Health Professional, or Qualified Mental Health Staff with appropriate, on-site supervision by a Qualified Mental Health Professional.**

**Compliance Assessment:** Substantial compliance (11/15)

**Factual Findings:**

**April 2017 Cermak Status Update**

Mental Health Department continues to provide 24 hour SMU screening for this cohort of detainees reentering restrictive settings. Mental health staff continues to conduct rounds on restrictive housing units at minimum weekly (in addition to the rounds conducted by Nursing/PCS). Please refer to 59 d. updates for discussion. Please see PDF Appendix for SMU Screening Compliance data.

**April 2017 Metzner assessment:** Substantial compliance continues

**n. Cermak shall ensure that a psychiatrist, physician or licensed clinical psychologist conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. An appropriately credentialed registered nurse may conduct the in-person evaluation of an inmate prior to a seclusion or restraint order that is limited to two hours in duration. Patients placed in medically-ordered seclusion or restraints shall be evaluated on an on-going basis for physical and mental deterioration. Seclusion or restraint orders should include sufficient criteria for release.**

**Compliance Assessment:** Substantial compliance (4/16)

**Factual Findings:**

**April 2017 Cermak Status Update**

A restraint audit completed by the Cermak nurse manager, Madonna Mikaitis, R.N. can be found in the PDF Appendix.

Notifications to Facility Director/Chief of Psychiatry are issued via a new process whereby the System generates an automatic notification when a Nurse completes charting for FLR deployment and subsequent face to face contacts during the time when FLR's are deployed. The notifications are sent out to arrive to the recipients' Cerner in box and accompanied with emails. These notifications prompt to conduct chart review when FLR were deployed at least once over the past 24 hours (in keeping with Cermak Policy and pursuant to the IL Mental Health and Developmental Disabilities Code). EMR created a pool of recipients of the said notification, thus, allowing the Chief of Psychiatry to delegate the task of chart review.

Cermak Policy I-01 Restraint and Seclusion reflects that when issuing restraining orders for

special populations (i.e. pregnant females, morbidly obsess with BMI> 40, BMI.35 with comorbidity, complex individual behavioral management treatment plans), patients will be evaluated and treated on a case by case basis.

**April 2017 Metzner assessment:** Substantial compliance continues.

o. **Cermak shall ensure an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among inmates. Crisis services shall not be limited to administrative segregation or observation status.**

p. **Cermak shall ensure that inmates have access to appropriate acute infirmary care, comparable to in-patient psychiatric care, within the Cermak facility.**

**Compliance Assessment:** partial compliance

**Factual Findings:**

**April 2017 Cermak Status Update**

There has been minimal change in the response to or compliance with timeliness in responding to HSRF since the last site visit, as the data has remained relatively unchanged. At this point we hypothesize that the reasons are multifactorial. Staffing has recently increased, however, newer staff have been in orientation and/or recently starting full assignments, so have not greatly impacted productivity. The access to care work group and pilot project in Division 9 is expected to uncover and assist the operational team in identifying solutions for contributing factors. Following significant increase in compliance and timeliness with response, we will look at the quality of the responses. What is encouraging is that more than 80% of the patients are seen for services despite not being as timely as we would like at this time. Please see Excel Appendix.

| | | OCTOBER 2016 | NOVEMBER 2016 | DECEMBER 2016 | JANUARY 2017 | FEBRUARY 2017 |
|---|---|---|---|---|---|---|
| COMPLIANCE | Patients Seen | 92% | 89% | 90% | 83% | 83% |
| TIMELINESS | Patients Seen on Time | 49% | 38% | 51% | 53% | 52% |
| QUALITY CLINIC | | | | | | |

**April 2017 Metzner assessment:** My April 2016 assessment included the following:

> QI data documents issues in meeting timelines for responses to routine mental health referrals related to the current policy and procedure that requires a face to face triage for routine referrals within 72 hours and periodic delays in receiving the referral from nursing staff in a timely manner. I discussed with staff potential revisions to the pertinent policy and procedure that will significantly decrease the lack of compliance. In addition, the process involved with the sending of the

mental health referrals from the nursing staff to mental health services needs to be improved.

Specifically, it remains my recommendation that timeframes for HSRFs specific to mental health services that have been triaged as routine referrals be changed to and appropriate clinical mental health response to 10 business days.

**Recommendations:** As above.

**60. Psychotherapeutic Medication Administration**

a. **Cermak shall ensure that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis for appropriateness or adjustment. Cermak shall ensure that changes to an inmate's psychotropic medications are clinically justified and documented in the inmate's medical record.**
b. **Cermak shall ensure timely implementation of physician orders for medication and laboratory tests. Cermak shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, including movement disorders, and provide treatment where appropriate.**

**Compliance Assessment:** Substantial compliance (4/17)

**Factual Findings:**

**April 2017 Cermak Status Update**

Periodic monitoring of blood levels of Lithium and Depakote is important for the safe administration of the said medications. It is suggested that blood levels are checked at least every 6 months, even if a patient remains asymptomatic and the dosage remains unchanged. A new Cerner alert was created. The logic now exists in EMR and, when Providers (both Medical and Psychiatric) try to order and, more importantly, reorder Lithium, Divalproex, and Atypical Formulary Antipsychotics, a new rule fires. If no Li and VPA levels have been ordered over the past 6 months, it prompts to order Li, VPA, and Lipid levels. In addition, the new rule will automatically fire with the tests for Non-fasting Lipids, Hb A1C, and weight measurement, if the said tests have not been performed over the past 6 months. As demonstrated by the chart, the frequency of medication monitoring has reached levels well above 90%.

Critical Medications Missing Alert has been built in Cerner. A list of patients who have missed 2 or more critical meds in the last 7 days is generated (including Clozapine and Decanoate formulations). This report is going to trigger a review by Providers. Additionally, Nurses need to report refusal of three or more doses to the provider and should do an eMERS. There needs to be a note entered into Cerner since many times patients have reported never being offered their

medications when they have in fact refused.

The use of Diphenhydramine at Cermak reflects concerns about safety. In Psychiatry Clinics its primary use is limited to treating extrapyramidal side effects of neuroleptic medications and alleviating secondary insomnia caused by SSRI induction. However, Providers, at times, expand its use to the treatment of idiopathic insomnia, in the absence of any other psychiatric conditions, including adjustment reactions. Diphenhydramine capsules have been implicated in numerous overdoses on campus and have become something that is hoarded and sold on the black-market. Cermak Psychiatry Leadership advised Psychiatrists to avoid using this medications in cases of idiopathic insomnia when sleep hygiene should have been a better therapeutic response to patients complaining of inability to sleep. Detainees who overdosed on Benadryl, as in any other relevant situation, have the Medication Hoarding Alert input in Cerner and require a clearance with Chief of Psychiatry should a Provider decide to re-challenge them with the said medication. CQI study (mentioned in 59e) revealed an outlying cluster of Benadryl prescriptions in Division X. Training with Providers was completed. Other measures are being introduced to limit Benadryl's availability: dispensation of liquid Diphenhydramine and limiting one time prescription to 2 weeks' worth of the medicine followed by the Sleep Hygiene training.

| | # of Med Order(person) | # of Lab Order | Ratio |
|---|---|---|---|
| Lithium (as of 3/22/2017) | 21 | 21 | 100.00% |
| Divalproex Sodium/ Valproic Acid (as of 3/22/2017) | 138 | 127 | 92.03% |
| Risperidone/ Ziprasddone/ Olanzapine (as of 3/28/2017) | 454 | 425 | 93.61% |

Neuroleptic polypharmacy reflective of providers' practice has been studied. Polypharmacy rates are below of what is expected in the community setting. Please refer to Polypharmacy in Severe Mental Illness QI in the APPENDIX.

**April 2017 Metzner assessment:** See above update. Compliance has been achieved.

## E. SUICIDE PREVENTION MEASURES

### 62. Suicide Precautions

a. **CCDOC shall ensure that, where suicide prevention procedures established jointly with Cermak involve correctional personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), correctional personnel perform and document their monitoring and checks.**
b. **Cermak shall ensure that, where suicide prevention procedures established jointly with CCDOC involve health care personnel for constant direct supervision of actively suicidal inmates or close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks), health care personnel perform and document their monitoring and checks.**
c. **CCDOC shall ensure that when an inmate is identified as suicidal, the inmate shall be searched and monitored with constant direct supervision until the inmate is transferred to appropriate Cermak staff.**
d. **Cermak shall develop and implement policies and procedures for suicide precautions that will set forth the conditions of the watch, including but not limited to allowable clothing, property, and utensils, in accordance with generally accepted correctional standards of care. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances.**

**Compliance Assessment:** Substantial compliance (11/15)

**Factual Findings:**

**April 2017 Cermak Status Update**

The Chief Psychologist worked with the IT team to ensure that the 'Serious Suicide Attempt History' alert in Cerner remains active across encounters. As such, the alert now automatically reactivates in the medical record with every admission.

See PDF Appendix for Suicide Detection and Prevention QI Report 2016 and Qtr. 1 2017

**April 2017 Metzner assessment:** Substantial compliance continues.

65. **Cermak shall ensure that inmates will only be removed from Suicide Precautions after a suicide risk assessment has been performed and approved by a Qualified Mental Health Professional, in consultation with a psychiatrist. A Qualified Mental Health Professional shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up.**

**Compliance Assessment:** Substantial compliance (11/15)

**Factual Findings:**

**April 2017 Cermak Status Update**

Please refer to QI reports referenced in provision #62.

**April 2017 Metzner assessment:** Substantial compliance continues.

## H. QUALITY MANAGEMENT AND PERFORMANCE MEASUREMENT

### 86. Quality Management and Performance Measurement

**a. Defendants shall each develop and implement written quality management policies and procedures, in accordance with generally accepted correctional standards, to regularly assess, identify, and take all reasonable measures to assure compliance with each of the provisions of this Agreed Order applicable to that Defendant.**

**b. Defendants shall each develop and implement policies to address and correct deficiencies that are uncovered during the course of quality management activities, including monitoring corrective actions over time to ensure sustained resolution, for each of the provisions of this Agreed Order applicable to that Defendant.**

**Compliance Assessment:** Substantial compliance (11/15)

**Factual Findings:**

**April 2017 Cermak Status Update**

Several additional QI projects have been undertaken since the last site visit that can found in the PDF Appendix.

Mental Health Group Satisfaction Surveys
Mental Health Group Programming Quality
Mental Health Grievances
'Top 29' Staff Assailants in 9/10 & SMI Status

**April 2017 Metzner assessment:** As has become the usual practice, the pre-site information packet, which included the QI appendix, was well done and extremely helpful. The QI studies were methodologically sound, well written and very relevant. Substantial compliance continues.

Nneka Jones, Psy.D. provided me with an overview of the CCDOC dashboard, which was part of a very impressive management information system. It is recommended that mental health services consult with Dr. Jones in the context of being able to use the dashboard for certain

mental health services QI projects.

**Appendix V**

**Please have the following information available in hard copy at the time of the site visit, and sent to me one week prior to the site visit in electronic form (but not in PDF) unless indicated otherwise. *Each* piece of information should cover the period since the last site visit.**

**Note: If any of the requests are too burdensome to produce, please contact me before attempting to produce such information.**

**Appendix I Agreed Order 5/13/10 MH provisions revised**

Using the word version of Appendix IV in my last submitted report, after each of the "recommendations" section add the following section: [**date of site visit] Cermak status update:** and complete a narrative with proof of practice as available. This document request is the most crucial document. *Please do not delete my April 2017 findings or recommendations except for provisions that have been found in substantial compliance for at least 18 months.*

Some of the following requests may be in the above document and only need to be referenced—it does not have to be provided twice.

**Mental Health System**

1. The mental health system organization chart (with both position and name of person filling the position and his/her credentials- e.g., degree).
2. Any new policies and procedures relevant to mental health services.
3. Any new program descriptions of the current mental health system.
4. Any other reports (i.e., internal or external reviews) relevant to the mental health system at CCDOC.

**Institutional Program Status**

1. Narrative summary of program status

**Staffing**

1. List authorized mental health staff positions by discipline (psychiatrists, psychologists, social workers, nursing staff, clerical staff, etc.) and by program/area (intake, crisis stabilization, mental health housing units, etc.). For each position, indicate the person's name, professional degree, start date, and percent of FTE if not full-time. If the position is vacant, provide the date it became vacant. For any staff on leave, indicate the date the leave began.

2. List any newly allocated mental health positions and the dates they were established.

**Census/Mental Health Roster**

1. The total number of inmates in the jail, total number in segregation units, total number of mental health caseload inmates, and total number of inmates in each program area (crisis observation, mental health housing, general population, etc.).

2. Statistical information pertinent to the reception center screening of inmates (i.e., number of persons on a daily, weekly, or monthly basis for the past six months, percentage of inmates who have positive screens from a mental health perspective, percentage of inmates with positive screens who enter the continuum of mental health services, percentage of all newly admitted inmates who enter the continuum of mental health services).

**Quality Improvement**

1. A copy of each relevant QA/QI audit conducted, preferably in electronic forms. For each audit provided, a description of:

    a. Statement of the issue being studied
    b. Methodology used
    c. Results
    d. Assessment of results
    e. Plan of action based on the assessment

**Suicide Prevention**

1. For any completed suicide, a copy of the mortality and review report.

**Additional Items**

1. Schedule of group therapies/structured out of cell therapeutic activities offered to inmates in the mental health housing units.*

2. Logs showing the use of restraints and seclusion, including the dates and times the orders were initiated, renewed, and discontinued, and the timing of nursing checks conducted.*

***Does not need to be sent in advance of site visit.***